Skyview SPRINGS
REHAB AND NURSING CENTER

December 19, 2019

Wietske G. Weigel-Delano, LTC Supervisor
Division of Long-Term Care
Department of Health
Office of Licensure and Certification
9960 Mayland Drive- Suite 401
Henrico, VA 23233-1485

RE: Skyview Springs Rehab and Nursing Center
Provider number: 495255

Dear Ms. Weigel-Delano

Enclosed you will find the Plan of Correction for the annual standard survey conducted at Skyview Springs ending on November 18, 2019.

Per instructions in your letter, we are providing the name and address of the following residents.
Resident #32, #36, #95, and #101 have the following doctor:

James Dale, MD
250 Memorial Drive
Luray, VA 22832
540-743-6558

Resident's #45 and #48 have the following doctor:

Ilija Rakaric
1920 Medical Avenue, Suite F
Harrisonburg, VA 22801
540-908-3085

If you require more information, please feel free to contact me at the facility.

Sincerely,

Pamela Jill P. Irby

Pamela Jill P. Irby, RN, LNHA
Administrator
December 12, 2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 11/12/2019 through 11/15/2019. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/12/19 through 11/15/19 and continued on 11/18/19. Complaints (VA00045418 was substantiated without deficiency and VA00044480 was unsubstantiated) were investigated during the survey. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 120 certified bed facility was 115 at the time of survey. The survey sample consisted of 55 current Resident record reviews and five closed Resident record reviews. The expanded sample consisted of six current Resident reviews. On 11/14/19 at 1:26 p.m., Immediate Jeopardy was identified in the area of Quality of Care at the Scope and Severity Level four - pattern, which constituted Substandard Quality of Care. On 11/14/19 at 1:56 p.m., the facility administration was informed. On 11/15/19 at 10:40 a.m. the Immediate Jeopardy was abated and was lowered to a Level II pattern. The Life Safety survey/report will follow.	F 000	The completion and submission of this credible allegation of compliance does not constitute an admission that the facility agrees with the allegations in the 2567. The facility is completing the allegation of compliance because it is required by State and Federal law. The facility disagrees with and disputes the deficiencies as stated and the scope and severity at which they are cited. Further, the facility disputes and disagrees with the accuracy of statements and other information relied upon in support of the stated deficiencies. The facility reserves its right to dispute, appeal and contest the stated deficiencies and take any action related to or arising therefrom in any other forum as needed.	
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights.	F 550	**F 550** It is the practice of this facility that residents have the right to exercise her or her rights as a resident of the facility and as a citizen of the United States.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Pamela Jill P. Irby, LNHA — TITLE: Administrator — (X6) DATE: 12/19/19

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 1 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 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.	F 550	I Discussion held with residents #9, #45, #87, #13, #31, #42, #3, #48, on their right to vote and will be registered to vote on the next election per their wishes. II The Activity director conducted an audit of residents with a BIMs of 8 and above to determine if they want to vote. The activity director or assistant activity assistant director will maintain a log of residents who have voiced a desire to vote. Any resident who wants to vote will be assisted to register to vote if needed and will be offered assistance to vote in local, county, state and national elections if they so desire. Resident choice to exercise their right to vote will be discussed with the resident on admission by the activity staff. The Activity director will monitor local, county, state and national election activity and include it in the activity calendar. III The facility Administrator (NHA) conducted education on 12/10/19 for • the activity staff regarding resident rights as it pertains to resident right to vote and in the activity staff responsibility to assist the resident to register to vote and assist with voting if the resident wants help.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 2 This REQUIREMENT is not met as evidenced by: Based on resident interview, facility staff interview, and facility document review, it was determined that the facility staff failed to assist residents to exercise their right to vote. The facility staff failed to offer residents who could vote the opportunity to do so for the November 2019 election. The findings include: On 11/13/19 at 11:00 a.m., a group interview was conducted with 12 residents. Of these 12 residents, eight (Residents # 9, #45, #87, #13 and GRP [group resident] #31, #42, #3, and #48) were coded as cognitively intact with brief interview for mental status scores at 13-15. As a part of the group interview, the surveyor asked the residents if they were given the opportunity, or if they were assisted to vote in the recent elections. All eight cognitively intact residents stated they were not offered the chance to vote. On 11/13/19 at 3:11 p.m., OSM (other staff member) #17, the activities director, was interviewed. When asked who is responsible for arranging for facility residents to vote, OSM #17 stated, "I am. But I did not do that this year. It completely slipped my mind. I was not in that job last year this time, so I haven't gone through it." When asked what the process is for assisting residents with exercising their right to vote, OSM #17 stated, "I am not really sure. I will check and get back to you." On 11/13/19 at 3:25 p.m., OSM #17 returned and stated, "It's pretty simple. If they want to vote, I	F 550	The NHA, Director of Nursing (DON) or Assistant Director of Nursing (ADON) conducted education for facility staff on 11/20/19 or before compliance date regarding • Resident rights as it pertains to resident right to exercise his or her rights as a resident of the facility and as a citizen of the United States IV The activity director will monitor the ongoing list of current residents to identify those who wish to vote in elections and provide assistance with the process as indicated. This audit will take place monthly to determine if the process was followed. Any discrepancy noted during the audit will be addressed at that time with assisting the resident in question to sign up for voting. Results of the audit will be submitted, by the activity director, monthly to the QAPI committee for its review and recommendations. Date of Compliance: 12/16/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 3 just give them this absentee ballot." When asked if anything else is involved, OSM #17 stated, "No. Not that I know of." When asked if there is a facility policy on resident voting, OSM #17 stated, "I don't know for sure. But I don't think so." On 11/15/19 at 11:10 a.m., ASM (administrative staff member) #1, the administrator, was informed of these concerns. A policy on resident voting was requested. On 11/18/19 at 10:20 a.m., ASM #1 told the surveyor that the facility does not have a policy on resident voting. No further information was provided prior to exit.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to assess a resident to administer their medications independently for one of 60 residents in the survey sample, Resident #87. Resident # 87 was observed administering her nebulizer treatments without supervision from a nurse on two occasions; review of the clinical record failed to evidence a self-administration of medication assessment for the resident. The findings include:	F 554	**F 554** It is the practice of this facility that the resident has the right to self-administer medications if the interdisciplinary team (IDT) has determined that this practice is clinically appropriate. **I** Resident #87 was able to self-administer her respiratory treatments and was doing so without incident. On 11/13/2019 a self-administration of medication assessment was completed on Resident # 87 by Director of Nursing and reviewed by the IDT team. She was identified as safe to self-administer a respiratory treatment. Her care plan was updated accordingly, and physician order obtained. The medication will be kept locked in the medication cart and when the treatment is to be completed, Resident # 87 will be provided with the medication solution. The licensed staff will sign off the treatment on the medication (treatment) administration record.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 554	Continued From page 4 Resident #87 was admitted to the facility on 10/16/18 with diagnoses that include but were not limited to: respiratory failure, chronic pain syndrome, COPD [general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis] (1) and anxiety disorder. The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 10/24/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. In Section G - Functional Status, the resident was coded as being independent in all of her activities of daily living except bathing in which she required limited assistance. In Section O - Special Treatments, Procedures and Programs, the resident was coded as using oxygen while a resident at the facility. Observation was made of Resident #87 on 11/12/19 at 1:43 p.m. The resident was observed standing at her bedside, and leaning over her bedside table using a nebulizer. There was no nurse in the area of her room. Resident #87 was observed again, on 11/12/19 at 4:12 p.m., standing at her bedside, leaning over her bedside table using a nebulizer. There was no nurse in the area of her room. An interview was conducted with Resident #87 on 11/13/19 at 9:48 a.m. When asked if the nurses stay with her while she does her nebulizer treatments, Resident #87 stated they did not, they set it up and leave the room and come back later to put the nebulizer away. Resident #87 was	F 554	II Residents will be allowed to self-administer medications if clinically appropriate. The IDT team will review residents on admission for desire to self-administer medications. Those residents who have already been deemed capable of self-administration will have a periodic assessment completed, based on changes in the residents medical and decision-making status. On 11/19/19 the Unit Managers (UMs), conducted an audit of residents in the facility to determine if any others wish to self-administer medications. Any resident identified during the audit had a self-administration for medication assessment completed to determine if it was clinically appropriate for the resident to self-administer. Care plans, if indicated, were updated accordingly. III The Director of Nursing or ADON completed education for the Unit managers and licensed nurses regarding: • F 554 as it pertains to resident right to self-administer medications and completion of a self-administration evaluation with IDT team review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 554	Continued From page 5 asked if the facility had completed any kind of assessment or questioned her to see if she could administer her medications independently. Resident #87 stated she did not recall anything like that. Review of the physician orders revealed documented orders for five different nebulizer treatments as follows: *Albuterol Sulfate Nebulization Solution [Albuterol used to prevent and treat difficulty breathing, wheezing, shortness of breath and chronic obstructive pulmonary disease. (2)]; 3 milliliters inhale orally via nebulizer every 4 hours as needed for shortness of breath/wheezing. * Brovana Nebulization Solution [Arformoterol inhalation used to control wheezing, shortness of breath, coughing, and chest tightness caused by chronic obstructive pulmonary disease. (3)], 15 MCG/2ML (micrograms per milliliters) 1 vial inhale orally via nebulizer two time a day for COPD. *Ipratropium-Albuterol Solution [The combination of albuterol and ipratropium is used to prevent wheezing, difficulty breathing, chest tightness, and coughing in people with chronic obstructive pulmonary disease (4)] 0.5 - 2.5 MG/3ML (milligrams per milliliters) inhale orally every 4 hours for COPD. *Pulmicort Suspension [used to prevent difficulty breathing, chest tightness, wheezing, and coughing caused by asthma. (5)] 0.5 MG/2ML inhale orally two time a day for COPD. * Yupeiri Solution [Revefenacin oral inhalation used to control wheezing, shortness of breath, coughing, and chest tightness in patients with chronic obstructive pulmonary disease. (6)], 175 MCG/3ML 3 milliliters inhale orally one time a day for COPD.	F 554	IV The DON or ADON will audit each new admission to verify that an assessment was completed to determine if the resident wishes to and has the ability to self-administer medications. This audit will be completed weekly X 4 weeks, then monthly X 2 months. Any discrepancy noted during the audit will be corrected at that time. Results of the audit will be submitted, by the DON, to the QAPI committee monthly for its review and recommendations. Date of compliance: 12/18/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 554	Continued From page 6 Review of the MARs (mediation administration records) revealed the resident receives nebulizer treatments at 12:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. Review of the clinical record failed to evidence documentation that a self-administration of medication assessment had been completed for Resident #87. The comprehensive care plan dated, 10/17/18 and revised on 9/23/19, documented in part, "Focus: Respiratory Disorders: (Resident #87) has a diagnosis of emphysema, COPD, and recent respiratory failure." The "Interventions" documented in part, "Administer medication as ordered q (every) HS (Hours of sleep) for COPD. See MAR. Nurse prepares and hands neb (nebulizer) treatment to resident and she administers the treatment and nurse returns to make sure neb is completed." This intervention was dated 9/19/19. An interview was conducted with LPN (licensed practical nurse) #4 on 11/13/19 at 3:42 p.m. When asked if the nurse stays with a resident during a nebulizer treatment, LPN #4 stated, "No. Ma'am. I don't." When asked if there should be an assessment completed to allow the resident to self-administer her medications, LPN #4 stated there was a form about two weeks ago but not sure, where it is kept. When asked about Resident #87 administering her nebulizer treatments by herself, LPN #4 stated, "She always does, I don't know if she has been assessed or where that is documented." An interview was conducted with ASM	F 554		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 554	Continued From page 7 (administrative staff member) #2, the director of nursing, on 11/13/19 at 4:02 p.m. When asked if a resident can be left alone with a nebulizer treatment, ASM #2 stated, "If the mask is on and they don't take it off." When asked if the nurse should be with the resident during the nebulizer treatment administration, ASM #2 stated, "Yes." When asked if Resident #87 had been assessed to see if she could self -administer her medications, ASM #2 stated, "There is one dated today." On 11/13/19 at 4:12 p.m. ASM #2 presented a document dated, 11/13/19, "Self Administration of Medication Assessment Tool" for Resident #87. The form documented under the "comments" section - "inhaler." This form did not address the assessment for the use of nebulizer treatments. The facility policy, "Policy and Procedure Self-Administration of Medications" documented in part, "Policy: Resident may self-administer medications from the bedside if the physician write an order that the resident may self-administer. Procedure: All resident that receive physician's orders for self-administration of medication from the beside will have an evaluation done by the nurse receiving the order and the interdisciplinary care plan team utilizing a documentation tool, for their appropriateness in self-administration of mediations. The Care Plan will indicate that the resident may self-administer mediations from the bedside and what medication can be self-administered. The interdisciplinary care plan team will review each resident quarterly for appropriateness to self-administer using the documentation tool developed for assessment purposes."	F 554		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 554	Continued From page 8 ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional vice president of clinical services, were made aware of the above concern on 11/15/19 at 2:00 p.m. No further information was provided prior to exit.	F 554		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584	**F 584** It is the practice of this facility to maintain a comfortable home-like environment. **I** There were no specific residents identified in the statement of deficiencies (form 2567). **II** As indicated in the 2567 the temperatures were adjusted by the maintenance director while making rounds with the surveyor. **III** The NHA completed an educational review for the maintenance staff regarding F-584 as it relates to monitoring facility temperatures and a comfortable home-like environment on 11/27/2109. **IV** The Maintenance director or Maintenance Assistant director will conduct audits of common area room temperatures and random resident room temperatures to ensure temperatures fall between 71 & 81 degrees. This audit will be conducted weekly X 4 then monthly X 2. Any discrepancy noted in the audit will be corrected at that time.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 584	Continued From page 9 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and facility staff interview, the facility staff failed to maintain a comfortable home-like environment in two of two common areas on the north wing, and in the main dining room. On 11/13/19, observations revealed temperatures in the north wing common areas were 61 degrees, and the temperature in the main dining room was 64 degrees. The findings include: On 11/13/19 at 8:58 a.m., the surveyor walked through the north wing of the facility. In both common areas at either end of the wing, the temperature felt cold. Two residents were observed in one of the common areas; both residents were wearing heavy sweaters and had their hands arms crossed tightly in front of them. On 11/13/19 at 9:04 a.m., OSM (other staff member) #7, the maintenance director, was asked to accompany the surveyor to the common areas and to take the temperatures. In the common area nearest the main entrance, the temperature registered 61 degrees. The common	F 584	The Maintenance director will submit results of the audits to the QAPI committee monthly for its review and recommendations. Date of Compliance: 12/16/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 584	Continued From page 10	F 584		

area at the opposite end of the unit also measured 61 degrees. OSM #7 stated, "It does feel like it's that cold in here. Let me check something." The surveyor accompanied OSM #7 to the thermostat on the hallway outside room #104. OSM #7 took the cover off the thermostat and stated, "No wonder it's so cold. The thermostat is set on air conditioning. I need to switch it to heat right now."

On 11/13/19 at 11:00 a.m., the surveyor arrived in the main dining room for the group meeting. Several of the residents were observed wearing heavy sweaters and/or coats, and stated they were cold. The surveyor asked OSM #7 to meet her in the main dining room and to take the temperature of the room. He measured the temperature and stated, "It says its 64, but I'd be surprised it's that much. It is my fault. Its cold in here, too, and the air conditioning is on in here. I will switch it over to heat."

On 11/18/19 at 11:02 a.m., OSM #7 was asked about the process for making sure the common areas of the facility are at a comfortable, home-like temperature. He stated, "I go at the discretion of the employees and patients. I know I have a certain temperature I have to keep in the building for the regulations." When asked what those temperatures are, OSM #7 stated, "72 or 73 to 85." He further stated, "With our system being as old as it is, it is just not efficient. The way the heat is set up, one thermostat does multiple rooms. One thermostat controls more than just one room, and it makes it difficult to keep everybody happy." When asked who is responsible for switching the air conditioner over to the heat, OSM #7 stated, "It has been really cold here these last couple of weeks. But I was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 584	Continued From page 11 not aware those areas were as cold as they were. I had been out of work. So had my assistant. We had both been out and I am just getting back. It's my responsibility to turn on the heat. I just had not had time to get to it. Those systems should have been converted to heat a month ago. I was out. It's my fault." On 11/15/19 at 11:10 a.m., ASM (administrative staff member) #1, the administrator, was informed of these concerns. A policy on maintaining comfortable temperatures in the building was requested. A review of the facility policy, "Preventive Maintenance Program," revealed no information concerning maintaining comfortable temperatures in the building. No further information was provided prior to exit.	F 584		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or	F 600	**F 600** It is the practice of this facility that each resident be free from abuse, neglect and exploitation. **I** Residents # 53, # 72, # 82 & # 304 have had no further incidents of resident to resident contact. **II** Facility staff will be alert to instances whereby resident to resident abuse may occur and work to intervene to deescalate the situation before residents hit each other.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 600	Continued From page 12 involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, facility staff failed to ensure two of 60 residents in the survey sample, Residents #72, and #82, were free from abuse. On 9/24/19, Resident #304 hit Resident #72 on the face with his open hand, causing a red area on Resident #72's face and pushed Resident #72, hitting his knee on the doorframe causing an abrasion. On 7/12/19, Resident #53 hit Resident #82 with her cane causing a bruises to her fifth digit of the right hand. The Findings Included: 1. Resident #72 was admitted to the facility on 10/09/2013. His diagnoses included diabetes, delusional disorders, and intellectual disability. Resident #72's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 10/15/2019. The Brief Interview for Mental Status (BIMS) scored Resident #72 at a 12, indicating mild impairment. Resident #72 was coded as requiring extensive assistance of one person for bed mobility, transfers, and dining. Resident #304 was not currently in the facility and was reviewed as a closed record. Resident #304 was admitted on 06/04/2019. His diagnoses included dementia, muscle weakness, and neutropenia (low levels of white blood cells). Resident #304's most recent MDS assessment was a quarterly assessment with an ARD of 09/11/2019. The BIMS scored Resident #304 at an 11, indicating mild to moderate impairment.	F 600	III The NHA or DON or ADON conducted an educational review for facility staff on 11.20/19 or before compliance date regarding: • F 600 as it relates to resident right to be free from abuse and • resident to resident abuse prevention. IV The NHA or DON or Unit Managers or Social Services staff or licensed nurse will conduct audits of resident interactions to validate there is no resident to resident abuse. This audit will take place at random times during the day and in different locations. The audit will be conducted 5 days a week for 2 weeks, then weekly for 4 weeks, then monthly X 2. Any discrepancy noted during the audit will be addressed with appropriate intervention. Results of the audit will be submitted by the Social Services staff, to the QAPI committee, monthly, for its review and recommendations. Date of compliance: 12/18/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 600	Continued From page 13 Resident #304 was coded as being independent in Activites of Daily Living (ADLs). A review of a Facility Reported Incident (FRI) final report, sent to the State Agency on 09/27/2019, described an incident that occurred on 09/24/2019 and documented: "On the evening of 09/24 [RESIDENT #304] abused [RESIDENT #72]. [RESIDENT #304] hit [RESIDENT #72] on the face with his open hand, causing a red area on [Resident #72's] face and pushed him hitting his knee on the door frame causing an abrasion." "The facility Administration has found that the abuse did take place." A review of both residents care plans revealed that the care plans were reviewed and updated following the incident. On 11/13/2019 at 4:02p.m. an interview was conducted with Licensed Practical Nurse (LPN) #3 regarding abuse. When asked to describe what constitutes abuse, LPN #3 described verbal, physical, emotional, and financial abuse. When asked what she would do if she witnessed abuse of one resident by another, LPN #3 stated she would first separate the residents and assess them for injuries, then, if needed, treat any injuries, then inform the MD (medical doctor), unit manager, and Director of Nursing. Finally, she would fill out an incident report. On 11/13/2019 at 4:15p.m., an interview was conducted with Certified Nurse Aide (CNA) #1 regarding abuse. CNA #1 was asked to describe abuse. She stated, "Verbal, physical, or emotional." When asked what she should do in the event of a resident on resident abuse situation, CNA #1 stated, "separate residents,	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 600	Continued From page 14 make sure they are okay, and notify the nurse, supervisor, and administrator". The facility policy, "Abuse Prohibition Standards of Practice" documented in part, "Each resident has the right to be free from abuse, neglect, misappropriation and exploitation. This includes but is not limited to verbal abuse, physical abuse, mental abuse, sexual abuse, corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Administrative Staff Member (ASM) #1, the Administrator, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 11/14/2019. No further information or documentation was provided. 2. On 7/12/19, Resident #53 hit Resident #82 with her cane causing a bruise to the tip of her fifth digit and in the bend of her fifth digit of the right hand. Resident #82 was admitted to the facility on 7/11/19, and readmitted to the facility on 10/11/19 with diagnoses that included but were not limited to, dementia, atrial fibrillation, morbid obesity, depression, and high blood pressure. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 10/17/19, coded the resident as scoring a "5" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded as requiring limited assistance of one or more staff members for most of her activities of daily living.	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 600	Continued From page 15 Resident #53 was admitted to the facility on 06/06/2019. Her diagnoses included Alzheimer's disease, diabetes, and dementia with behavioral disturbance. Resident #53's most recent MDS assessment was a quarterly assessment with an ARD of 09/26/2019. The BIMS scored Resident #53 at a nine, indicating significant impairment. Resident #53 was coded as being independent in most ADLs. Review of the FRI final report, sent to the State Agency on 07/16/2019, described an incident that occurred on 07/12/2019. The FRI documented in part, "[RESIDENT #53] and [RESIDENT #82] had an altercation with each other where they threw water on each other and [RESIDENT #53] hit [RESIDENT #82] with her cane causing a bruise to the tip of her 5th digit and in the bend of her 5th digit of the right hand." A review of both residents care plans revealed the staff reviewed and updated the comprehensive care plans to address the incident for both residents. Administrative Staff Member (ASM) #1, the Administrator, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 11/14/2019. No further information or documentation was provided.	F 600		
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	F 622	F 622 It is the practice of this facility to send care plan goals with a resident upon transferred. I The care plans goals were sent with Resident # 19, # 56, #81, # 82 and # 105. However, proof of such could not be located as the checklist of items to send with the resident accompanied the resident to the hospital due to the fact that they were pasted to the envelope.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 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 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.	F 622	II The checklist for hospital transfer / discharges was reviewed and revised. Transfer folders were set up with a copy of the transfer checklist being attached to the envelope with a staple. Licensed staff will follow the transfer checklist instructions when sending a resident out to the hospital. III The DON or ADON provided education for the licensed staff and unit clerks On 11/27/2019 or before compliance date regarding: • regulation F 622 as it relates to transfer and discharge requirements and • preparation of items on the checklist for resident transfer • as well instructions to not send the checklist to the hospital • documentation of items being sent with the resident which may include scanning the checklist into the resident EMR IV The DON or ADON will conduct an audit of resident transfers to ensure that the appropriate paperwork was sent with the resident. The audit will be an ongoing audit, conducted 5 days per week during AM clinical review. Any discrepancy noted during the audit will be corrected at that time.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 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 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	F 622	The DON will submit results of the audit monthly to the QAPI committee for its review and recommendations. Date of compliance: 12/18//2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 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, it was determined the facility staff failed to evidence documentation that the care plan goals were sent to the hospital upon transfer for 5 of 60 Residents in the survey sample, Residents #56, #19, #81, #82, and #105 The findings include: 1. On 10/8/19, Resident #56 was transferred to the hospital, there was no documented evidence that the comprehensive care plan goals were sent to the receiving facility. Resident #56 was admitted to the facility on 7/6/18, with a recent readmission on 10/14/19 with diagnoses that included but were not limited to: congestive heart failure (1), anxiety disorder, high blood pressure, gout (2), and dementia. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/30/19, 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. A nurse's note dated, 10/8/19 at 4:37 a.m. documented Resident #56 was experiencing shortness of breath and documented in part, Resident being sent to ED (emergency department) for eval (evaluation) and treat (treatment)." The physician order dated, 10/8/19 at 4:45 a.m.	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 documented, "Sent to ED for eval and treat." An interview was conducted with LPN (licensed practical nurse) #4 on 11/13/19 at 3:42 p.m., regarding what documents the facility sends with residents' transferred to the hospital. LPN #4 stated the face sheet, the medication list, the progress notes, medication administration record, bed hold policy." When asked where staff document that these items were sent to the hospital, LPN #4 stated, "We have a folder that has the check list on it and we send that to the hospital." The envelope with the checklist was reviewed with LPN #4. The checklist documented in part, "North Hall Transfer Information: Items sent: face sheet, physician orders, code status order, MAR & TAR (medication administration record & treatment administration record), copy of care plan, bed hold policy (send copy, keep original); transfer policy (send copy, keep original), immunization record, and Nursing notes." At the bottom of this form, it was documented, "Initial each item as completed and sent & make a copy of this sheet and place in unit manager's folder for facility." When asked if she makes a copy of the checklist, LPN #4 stated, "I don't. I won't lie to you." An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 11/13/19 at 4:02 p.m., regarding the information sent with residents' when they are transferred to the hospital. ASM #2 stated, "The orders, the consent for bed hold, the care plan goals, facesheet, copy of the DNR (do not resuscitate), advanced directives, pertinent information of why they are being sent, history and physical, most recent doctor progress notes and any pertinent laboratory tests or x-ray	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 results." When asked where staff document this information, ASM #2 stated, "In the progress notes." The envelope and form that LPN #4 shared with this surveyor was shown to ASM #2. ASM #2 stated, "Honestly, I've never seen this form." On 11/13/19 at 4:50 p.m. ASM #1, the administrator, informed this surveyor that the facility did not have any documentation that the care plan goals were sent to the hospital for Resident #56. The facility policy, "Transfer or Discharge Documentation Standard of Practice" documented in part, "7. Should a resident be transferred or discharged for any reason, the following information will be communicated to the receiving facility or provider: a. The basis for the transfer or discharge; if the resident is being transferred or discharged because his or her needs cannot be met at the facility, documentation will include: the specific resident needs that cannot be met, this facility's attempt to meet those needs and the receiving facility's services that are available to meet those needs. b. Contact information of the practitioner responsible for the care pf the resident. c. Resident representative information including contact information. d. Advanced Directive information. e. All special instructions or precautions of ongoing care, as appropriate. f. Comprehensive care plan goals. g. All other necessary information, including a copy of the residents discharge summary and any other documentation, as applicable to ensure a safe and effective transition of care." ASM #1, the administrator, ASM #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
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 nursing and ASM #3, the regional vice president of clinical services, were made aware of the above concern on 11/15/19 at 2:00 p.m. No further information was provided prior to exit. References: (1) Congestive heart failure: abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 138. (2) Gout is a disease in which a defect in uric acid metabolism causes the acid and its salts to accumulate in the blood and joints, causing pain and swelling of the joints. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 252. 2. The facility staff failed to evidence the comprehensive care plan goals were sent to the hospital for Resident # 19 on 10/16/19, hospital transfer. Resident #19 was admitted to the facility on 11/7/18, with a recent readmission on 11/7/19 with diagnoses that included but were not limited to: anxiety disorder, dementia, seizures, and stroke. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/6/19, coded the resident as scoring a "9" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make daily cognitive decisions.. The nurse's note dated, 10/16/19 at 8:34 a.m. documented, "Resident found beside of bed on	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 back. When attempted to move he complained of back and head pain, resident to be sent for eval (evaluation) and treat (treatment)." The physician order dated, 10/16/19, documented, "Send resident to ER (emergency room) for eval and treat." An interview was conducted with LPN (licensed practical nurse) #8 on 11/18/19 at 12:39 p.m., regarding the documents that are sent with residents being transferred to the hospital. LPN #8 stated, "Face sheet, MAR/TAR, orders, code status, note with our assessment, vital signs, who was made aware, immunization record, recent laboratory work, the order to send them out, transfer papers, bed hold paperwork and care plan goals. "When asked where staff document the information sent to the hospital, LPN #8 stated, "We do a checklist that goes to the hospital." When asked if she kept a copy of that checklist, LPN #8 stated, "No, I haven't kept a copy of it before, but did today when I sent someone out." On 11/18/19 at 2:53 p.m. OSM (other staff member) #16, medical records, stated that the facility did not have documentation that the care plan was sent to the hospital on transfer for Resident #19 on 10/16/19. ASM #1, the administrator, ASM #2 the director of nursing and ASM #3, the regional vice president of clinical services, were made aware of the above concern on 11/18/19 at 3:52 p.m. No further information was provided prior to exit. 3. The facility staff failed to evidence that the	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 comprehensive care plan goals were sent to the hospital transfer on 10/1/19 for Resident #81. Resident #81 was admitted to the facility on 9/20/19, with a readmission on 10/9/19 with diagnoses that included but were not limited to: cancer of the lung, anxiety disorder, stroke, chronic pain syndrome, and high blood pressure. The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 11/7/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) scoring, indicating she was capable of making daily cognitive decisions. The nurse's note dated, 10/1/19 at 8:24 a.m. documented, "CNA (certified nursing assistant) retrieved this nurse voicing that resident has blood coming from her mouth. Upon entering room, this nurse observed resident with dark black emesis coming from her mouth. Resident with c/o (complaint of) abd (abdominal) discomfort and being nauseous. Resident noted with a large BM (bowel movement) on Sunday 9/29/19 and abd was soft and non-distended. Order from NP (nurse practitioner) to send resident to ER (Emergency room) for eval (evaluation). Report called to (initials of hospital) and daughter made aware via phone. 911 (emergency services) activated." An interview was conducted with LPN (licensed practical nurse) #4 on 11/13/19 at 3:42 p.m., regarding the documents sent with residents' that are transferred to the hospital. LPN #4 stated the face sheet, the medication list, the progress notes, medication administration record, bed hold policy." When asked where staff document that	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 these items were sent to the hospital, LPN #4 stated, "We have a folder that has the check list on it and we send that to the hospital." The envelope with the checklist was reviewed with LPN #4. The checklist documented in part, "North Hall Transfer Information: Items sent: face sheet, physician orders, code status order, MAR & TAR (medication administration record & treatment administration record), copy of care plan, bed hold policy (send copy, keep original); transfer policy (send copy, keep original), immunization record, and Nursing notes." At the bottom of this form, it was documented, "Initial each item as completed and sent & make a copy of this sheet and place in unit manager's folder for facility." When asked if she makes a copy of the checklist, LPN #4 stated, "I don't. I won't lie to you." An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 11/13/19 at 4:02 p.m., regarding the information sent with residents' when they are transferred to the hospital. ASM #2 stated, "The orders, the consent for bed hold, the care plan goals, face sheet, copy of the DNR (do not resuscitate), advanced directives, pertinent information of why they are being sent, history and physical, most recent doctor progress notes and any pertinent laboratory tests or x-ray results." When asked where staff document this information, ASM #2 stated, "In the progress notes." The envelope and form that LPN #4 shared with this surveyor was shown to ASM #2. ASM #2 stated, "Honestly, I've never seen this form." On 11/13/19 at 4:50 p.m. ASM #1, the administrator, informed this surveyor that the facility did not have any documentation that the	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 care plan goals were sent to the hospital for Resident #81. ASM #1, the administrator, ASM #2 the director of nursing and ASM #3, the regional vice president of clinical services, were made aware of the above concern on 11/15/19 at 2:00 p.m. No further information was provided prior to exit. 4. On 10/8/19, the facility initiated transfer of Resident #82 to the hospital. The facility staff failed to evidence that the comprehensive care plan goals were sent with the resident for this transfer to the hospital. Resident #82 was admitted to the facility on 7/11/19 with a recent readmission on 10/11/19, with diagnoses that included but were not limited to: dementia, obesity, depression, high blood pressure and atrial fibrillation (1). The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 10/17/19, coded the resident as scoring a "5" on the BIMS (brief interview for mental status) score, indicating she was severely impaired to make daily cognitive decisions. The physician order dated, 10/8/19 at 8:18 a.m. documented, "Send to emergency room for eval and treat." The "Notice of Emergency Transfer" dated 10/8/19, documented in part, "The Reason for the transfer was: chest pain/SOB (shortness of breath), (a circle with a line through it indicating 'no') BP (blood pressure), unresponsive."	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 Review of the clinical record failed to evidence the comprehensive care plan goals were sent to the hospital with the resident on 10/8/19. See above interviews related to this investigation. On 11/13/19 at 4:50 p.m. ASM (administrative staff member) #1, the administrator, informed this surveyor that the facility did not have any documentation that the care plan goals were sent to the hospital for Resident #82. No further information was provided prior to exit. References: (1) Atrial fibrillation a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. 5. The facility staff failed to evidence that Resident #105's comprehensive care plan goals were provided to the hospital for a facility initiated hospital transfer of Resident #105 on 8/19/19. Resident #105 was admitted to the facility on 8/9/19. Diagnoses include, but are not limited to a compression fracture in his spine, dementia, and heart failure. On the most recent MDS (minimum data set), an admission assessment with an assessment reference date of 8/16/19, Resident #105 was coded as being moderately cognitively impaired for making daily decisions, having scored 11 out of 15 on the BIMS (brief interview for mental status).	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 A review of Resident #105's clinical record revealed a document, "Notice of Emergency Transfer," which documented, in part: "This notice is to confirm that on 8/19/19; [Resident #105] was transferred from [name of facility] on an emergent basis to [name of receiving hospital]. The reason for the transfer was decreased oxygenation and AMS (altered mental status)." Further review of Resident #105's clinical record failed to reveal evidence that his comprehensive care plan goals were sent to the receiving hospital. An interview was conducted with LPN (licensed practical nurse) #4 on 11/13/19 at 3:42 p.m. When asked what documents are sent with a resident transferred to the hospital, LPN #4 stated, the face sheet, the medication list, the progress notes, medication administration record, bed hold policy." When asked where it is documented that these items were sent to the hospital, LPN #4 stated, "We have a folder that has the check list on it and we send that to the hospital." The envelope with the checklist was reviewed with LPN #4. The checklist documented in part, "North Hall Transfer Information: Items sent: face sheet, physician orders, code status order, MAR & TAR (medication administration record & treatment administration record), copy of care plan, bed hold policy (send copy, keep original); transfer policy (send copy, keep original), immunization record, and Nursing notes." At the bottom of this form, it was documented, "Initial each item as completed and sent & make a copy of this sheet and place in unit manager's folder for facility." When asked if she makes a copy of the checklist, LPN #4 stated, "I don't. I won't lie to you."	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 11/13/19 at 4:02 p.m., ASM #2 was asked what information is sent with the resident when they are transferred to the hospital. ASM #2 stated, "The orders, the consent for bed hold, the care plan goals, face sheet, copy of the DNR (do not resuscitate), advanced directives, pertinent information of why they are being sent, history and physical, most recent doctor progress notes and any pertinent laboratory tests or x-ray results." When asked where this information is documented, ASM #2 stated, "In the progress notes." The envelope and form that LPN #4 shared with this surveyor was shown to ASM #2. ASM #2 stated, "Honestly, I've never seen this form." On 11/13/19 at 4:50 p.m. ASM #1, the administrator, informed this surveyor that the facility did not have any documentation that the care plan goals were sent to the hospital for Resident #105. No further information was provided prior to exit.	F 622		
F 623 SS=D	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	F 623	**F 623** It is the practice of this facility to notify the State Long-Term care Ombudsman when a resident is transferred and provide the resident and/or responsible party with the reason for the transfer. I The State LTC Ombudsman was notified, on 11/14/2019 of Resident # 19 transfer to the ER with return the same day.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 29 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 (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;	F 623	Resident transfers with admission have been reported per regulation to the State Ombudsman. The Ombudsman has requested to be notified monthly. Past non-compliance with sending a notice for residents only sent to the ER for evaluation, which returned the same day, cannot be corrected. II Social Services staff will notify the Ombudsman of transfers to the hospital to include those residents which were not admitted. The Social Services staff conducted an audit, retro 30 days to identify any resident that was transferred to the ER or was a direct admit to the hospital from an outside appointment. The State Ombudsman was notified of any resident that met these criteria. III The facility NHA or designee conducted an educational review on 11/27/2019 for the Social services staff of F 623 as it pertains to notification to the State LTC Ombudsman for transfers and discharges. IV The Social Service director or facility NHA will conduct an audit of resident transfers to ensure that notification of the transfer(s) was made to the State LTC Ombudsman. Any discrepancy noted during the audit will be addressed at that time.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 30 (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 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	F 623	The Social services director will submit results of the audit to the QAPI committee monthly for its review and recommendations. Date of Compliance: 12/18/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 31 to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to notify the ombudsman of a transfer to the hospital and evidence a notice was given to the resident and/or responsible party with the reason for the transfer for one of 60 residents in the survey sample, Resident #19. The findings include: Resident #19 was admitted to the facility on 11/7/18, with a recent readmission on 11/7/19 with diagnoses that included but were not limited to: anxiety disorder, dementia, seizures, and stroke. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/6/19, coded the resident as scoring a "9" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make daily cognitive decisions. The nurse's note dated, 10/16/19 at 8:34 a.m. documented, "Resident found beside of bed on back. When attempted to move he complained of back and head pain, resident to be sent for eval (evaluation) and treat (treatment)." The physician order dated, 10/16/19,	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 32 documented, "Send resident to ER (emergency room) for eval and treat." An interview was conducted with LPN (licensed practical nurse) #8 on 11/18/19 at 12:39 p.m. When asked what documents are sent to the hospital when a resident is transferred, LPN #8 stated, "Face sheet, MAR/TAR (medication administration/treatment administration), orders, code status, note with our assessment, vital signs, who was made aware, immunization record, recent laboratory work, the order to send them out, transfer papers, bed hold paperwork and care plan goals. "When asked where staff document what is sent with the resident, LPN #8 stated, "We do a checklist that goes to the hospital." When asked if she kept a copy of that checklist, LPN #8 stated, "No, I haven't kept a copy of it before but did today when I sent someone out." When asked if she notifies the ombudsman, LPN #8 stated that the social workers take care of that. When asked if she kept a copy of the transfer notice provided to the resident and/or resident representative, LPN #8 stated that she did not keep a copy. On 11/18/19 at 2:53 p.m., OSM (other staff member) #16 stated that social services did not notify the ombudsman regarding the transfer. OSM #16 stated she could not find documentation that the resident and/or resident representative were provided written documentation of the reason for transfer. An interview was conducted with OSM #3, the social worker, on 11/18/19 at 3:08 p.m. When asked why the ombudsman was not notified of Resident #19's transfer to the hospital on 10/16/19, OSM #3 stated, "It's my fault. He came	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 34 facility staff coded the Resident #45 as not being a current tobacco user on the most recent comprehensive assessment dated 5/25/19, when the resident stated during interview that (Resident #45) does go outside to smoke about twice a day with another resident. The findings include: 1. Resident #32 was admitted to the facility with the diagnoses including but not limited to, diabetes, nicotine dependence, angina, hemiplegia, mood disorder, depression, epilepsy, high blood pressure, cerebrovascular disease, and aphasia. The annual MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 9/11/19 coded the resident as being cognitively intact in ability to make daily life decisions. Further review of the MDS revealed that in Section J 1300, "Current Tobacco Use" Resident #32 was marked as "0" for "No." (The alternative option was to mark "1" for "Yes"). On 11/14/19 at 9:15 AM and on 11/14/2019 at 4:12 PM, Resident #32 was observed on the south unit outside patio area smoking. On 11/18/19 at 2:30 PM, an interview was attempted with Resident #32. Resident #32 was in (Resident #32) bed watching TV. (Resident #32) was difficult to communicate with due to the effects of a stroke. (Resident #32) was able to point to things, and indicate yes and no. Other spoken words were more difficult to understand by this surveyor. During the interview, the resident indicated through yes and no questions, that (Resident #32) had been instructed that the facility was a non-smoking facility but (Resident	F 641	III The DON or ADON reviewed the regulation F 641 as it relates to MDS accuracy with the IDT team and MDS nurses on 12/02/19. IV The lead MDS nurse will conduct an audit of completed MDS's to validate that the MDS accurately reflects if the resident smokes. This audit will be conducted weekly x 8 weeks, on 25% of the MDS's completed that week, then monthly X 2 months on 10% of the MDS's completed that month. Any discrepancy noted during the audit will be corrected at that time. The lead MDS nurse will submit results of the audit monthly to the QAPI committee for its review and recommendations. Completion date: 12/16/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 35 #32) wanted to smoke anyway and was not going to give up smoking. A review of the clinical record revealed the following social worker notes: On 5/7/19, 5/14/19, 5/21/19, 5/28/19, 6/4/19, 6/18/19, 7/2/19, 7/12/19, 7/16/19, 7/30/19, 8/6/19, 8/14/19, and 8/26/19, that documented, "....(Resident #32) smokes when (Resident #32) knows a family member or friend must be with (Resident #32). (Resident #32) is wearing a nicotine patch, but continues to sneak smoke...." (Note: the order for the patch was during the month of April. There were no nicotine patch orders in place for the above identified dates. The wording of each note was identical, with the same spacing error of the comma after the word patch indicating the note was a copy/paste note week after week.) On 9/4/19 was documented, "....(Resident #32) smokes when (Resident #32) knows a family member or friend must be with (Resident #32). (Resident #32) is giving other residents cigarettes. (Resident #32) has been educated. Denies this behavior...." On 9/17/19, 9/25/19, and 10//1/19 was documented, "....(Resident #32) continues to smoke when (Resident #32) has been educated on smoking policies. (Resident #32) is providing cigarettes to other residents in the facility, and denies behaviors when questioned...." On 10/22/19 was documented, "....Resident continues to smoke when (Resident #32) has been educated on smoking policies. Resident is	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 36 providing cigarettes to other residents in the facility, and denies giving other residents cigarettes. Resident picking up cigarette butts in the parking lot to smoke. Resident denies this behavior...." On 11/7/19 was documented, "....resident continues to smoke when (Resident #32) has been educated on smoking policies. (Resident #32) is providing cigarettes to other residents in the facility, and denies behaviors when questioned. Resident also is picking up cigarette butts in the parking lot...." The comprehensive care plan dated 3/3/17, documented, "Behaviors: (Resident #32) is aware this is a non smoking facility." The interventions included: "3/3/17 - Encourage pt (patient) not to smoke or ask visitors for cigarettes due to no smoking policy. 3/3/17 - Encourage (Resident #32) to not get cigarettes out of ashtrays out side. 3/3/17 - Review smoking policy with resident as needed." On 11/18/19 at 12:06 PM in an interview with LPN #2 (Licensed Practical Nurse) the MDS nurse, she stated that the resident was marked as not being a current tobacco user because the facility is a non-smoking facility and (Resident #32) was not supposed to be smoking. When asked if the MDS assessment is coded, based on the facility policy or based on what the resident is actually doing, LPN #2 stated it is coded based on the resident. When asked if the MDS assessment should have coded (Resident #32) as a current tobacco user because (Resident #32) was smoking, LPN #2 stated, "Yes."	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 37 On 11/18/19 at 5:24 PM in a follow up interview with LPN #2 when asked about facility policy for accurately completing the MDS she stated they use the RAI manual (Resident Assessment Instrument). According to the RAI Manual 3.0, Version 1.16, dated October 2018, Pages J-23 and J-24 documented: J1300: Current Tobacco Use Health-related Quality of Life: The negative effects of smoking can shorten life expectancy and create health problems that interfere with daily activities and adversely affect quality of life. Planning for Care: This item opens the door to negotiation of a plan of care with the resident that includes support for smoking cessation. If cessation is declined, a care plan that allows safe and environmental accommodation of resident preferences is needed. Steps for Assessment 1. Ask the resident if he or she used tobacco in any form during the 7-day look-back period. 2. If the resident states that he or she used tobacco in some form during the 7-day look-back period, code 1, yes. 3. If the resident is unable to answer or indicates that he or she did not use tobacco of any kind during the look-back period, review the medical record and interview staff for any indication of tobacco use by the resident during the look-back period. Coding Instructions	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 38 Code 0, no: if there are no indications that the resident used any form of tobacco. Code 1, yes: if the resident or any other source indicates that the resident used tobacco in some form during the look-back period. On 11/18/19 at 6:05 PM, ASM #1 (Administrative Staff Member) was made aware of the findings. No further information was provided. 2. Resident #45 was admitted with the diagnoses of but not limited to, diabetes, gout, macular degeneration, vascular dementia, peripheral vascular disease, anxiety disorder, depression, high blood pressure, congestive heart failure, and chronic obstructive pulmonary disease. The quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 9/25/19 coded the resident as being cognitively intact in ability to make daily life decisions. J1300 "Current Tabaco use" Yes or No was blank. The significant Change in Status MDS assessment with an ARD of 5/29/19 coded Resident #45 under "Current Tabaco use" as "No". Resident #45 was not observed to be smoking during the survey. On 11/14/19 at 8:55 AM, the resident stated that (Resident #45) does go outside to smoke about twice a day with another resident. Resident #45 stated the other resident pushes (Resident #45) in (Resident #45) wheel chair to the smoking area. Resident #45 stated on days that are cold, (Resident #45) might not go out any to smoke. The weather during survey was cold. A review of the comprehensive care plan	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 39 revealed one dated 11/10/15 for "Cardiac - The resident has coronary artery disease (CAD) r/t (related to) Atrial Fibrillation, Hypertension, smoking." This care plan included the intervention dated 1/20/19, "Encourage resident to refrain from smoking." There was no other interventions for this resident regarding smoking in her care plan before survey. Review of the clinical record revealed the following notes: A note written by ASM #2 the Director of Nursing, dated 2/5/19, that documented, "IDT members met to review residents non compliance with facility smoking policy. (Resident #45) has been made aware several times this is a non smoking facility. The only way (Resident #45) can smoke is with a family member or a friend. Resident continues to go smoke on own. Has been re-educated over and over by staff member. Will continue to monitor." Social worker notes dated 4/10/19, 4/16/19, 4/23/19, 8/15/19, 8/26/19, documented, "....(Resident #45) continues to smoke , (Resident #45) is aware this is a non smoking facility and is not to be smoking without a family member or a friend accompanying (Resident #45)...." Social worker notes dated 8//15/19, 8/26/19, 9/4/19, 9/10/19, 9/17/19, 9/25/19, 10/1/19, 10/27/19, 10/27/19, 10/29/19, and 11/7//19, that documented, "....(Resident #45) continues to smoke , (Resident #45) is aware this is a non smoking facility and is not to be smoking without a family member or a friend accompanying (Resident #45). She will get another resident to	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 40 take her off the facility premises to smoke...." On 11/18/19 at 12:06 PM in an interview with LPN #2 (Licensed Practical Nurse) the MDS nurse, she stated that the resident was marked as not being a current tobacco user because the facility is a non-smoking facility and the resident was not supposed to be smoking. LPN #2 further stated that she did not know when the resident started smoking but was not smoking when (Resident #45) was admitted to the facility. When informed that there were notes documented as early as February 2019 that the resident was smoking and the resident stated she was smoking and LPN #2 was asked if the MDS assessment is coded, based on the facility policy, or based on what the resident is actually doing. LPN #2 stated that it is coded based on the resident and therefore should have coded (Resident #45) as a current tobacco user because (Resident #45) was smoking. On 11/18/19 at 6:05 PM, ASM #1 (Administrative Staff Member) was made aware of the findings. No further information was provided.	F 641		
F 656 SS=D	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	F 656	F 656 It is the practice of this facility to implement the comprehensive care plan I When getting dressed Resident # 25 decided to wear shorts which exposed his leg bag. He opted not to wear a cover over it that day, per his right to do so. The urinary drainage bag was covered after discussion with Resident #25. The care plan was reviewed and updated to reflect that the resident has the right to refuse use of a dignity bag on the drainage bag but will be encouraged to use one.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 41 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 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, clinical record review, and facility documentation review, the facility staff failed to implement the comprehensive care plan for one Resident, Resident #25, in a sample of 60 Residents. The facility staff failed to implement the interventions	F 656	II Nursing staff will follow the care plan for use of dignity bags for residents with catheters. The Unit Manager(s) conducted an audit On 11/15/2019 of residents with catheters to verify that each had a dignity bag over the drainage bag per the comprehensive care plan. There were no other issues identified with dignity bags during the audit. III The DON or ADON provided an educational review on 11/20/19 or before compliance date for the nursing staff regarding: • F 656 developing and implementing comprehensive care plans. • Following the care plan to include use of dignity bags over urine drainage bags IV The DON or Unit Manager(s) will conduct an audit of catheters in use to verify that the care plan is being followed in relation to urine drainage bags. This audit will take place weekly X 4 then monthly X 2. Any discrepancy noted during the audit will be corrected at that time. The DON will submit results of the audit monthly to the QAPI committee for its review and recommendations. Date of compliance: 12/16/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 42 for Resident #25's urinary catheter care plan. The Findings Included: Resident #25 was admitted to the facility on 06/21/2019. His diagnoses included anxiety disorder, depression, and urinary retention. Resident #25's most recent Minimum Data Set (MDS) assessment was a Significant Change Assessment with an Assessment Reference Date (ARD) of 09/04/2019. The Brief Interview for Mental Status (BIMS) scored Resident #25 at a 15, indicating no impairment. Resident #25 was coded as requiring extensive assistance of two or more people for all Activities of Daily Living (ADLs). On 11/12/2019 at 12:06p.m., an observation was made of Resident #25 in his room watching TV in his wheelchair. It was noted at that time that the urine drainage bag from Resident #25's catheter was strapped to his thigh and visible, with no privacy cover in place. When the resident was asked about the lack of a cover, the resident stated it did not bother him. On 11/12/2019 at 3:26p.m., a second observation of Resident #25 was made. Resident #25 was observed again in his wheelchair with the urine drainage bag visible strapped to his thigh. A review of Resident #25's comprehensive care plan most recently revised on 09/11/2019 revealed, under the focus "the resident has obstructive uropathy related to BPH (1)", the following intervention: "check for placement of privacy cover q (every) shift". On 11/15/2019 at 10:224a.m., an interview was	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 43 conducted with [LPN] regarding catheter care. When asked if urine drainage bags should be covered, [LPN] stated, "Yes". The facility policy, "Foley Catheter Care and Maintenance" documented in part, "Maintenance of Residents Dignity with a Urinary Drainage System: Any resident who maintains a urinary drainage system, is to have it covered and the device remain off the floor at all times to maintain their dignity." Administrative Staff Member (ASM) #1, the Administrator, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 11/14/2019. No further documentation was provided. 1. The prostate is a gland in men. It helps make semen, the fluid that contains sperm. The prostate surrounds the tube that carries urine out of the body. As men age, their prostate grows bigger. If it gets too large, it can cause problems. An enlarged prostate is also called benign prostatic hyperplasia (BPH). Most men will get BPH as they get older. Symptoms often start after age 50. - https://medlineplus.gov/enlargedprostatebph.html	F 656		
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	F 657	**F 657** It is the practice of this facility to review or revise the comprehensive care plan with changes in condition. **I** The care plan for Resident # 19 was reviewed by the interdisciplinary team (consisting of Nursing, Social Services and therapy) following his falls of 2/8/19 & 5/24/19 however, documentation of that review was missing. Correction cannot be obtained at this time.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 657	Continued From page 44 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to review and/or revise the comprehensive care plan to address a fall for one of 60 residents in the survey sample; Resident #19. The findings include: Resident #19 was admitted to the facility with the diagnoses of but not limited to mental and behavioral disorders, sepsis, anxiety disorder, bladder neuromuscular dysfunction, vascular dementia, seizures, stroke, aphasia, and benign prostatic hyperplasia. The quarterly MDS	F 657	II The DON or ADON and members of the IDT team reviewed residents with falls retro 30 days to verify that the care plans for resident(s) with a fall were reviewed or updated with a new intervention. Any discrepancy noted during the audit was addressed at that time. The IDT team members review falls together, weekly at the facility risk meeting at which time the review will be validated as complete. III The DON or facility NHA conducted an educational review on 11/0/19 or before compliance date for the IDT team and licensed nurses regarding F 756 as it relates to care plan review with revision as necessary following a fall. IV The DON or facility NHA will conduct an audit of resident(s) with falls to ensure that the care plan was reviewed and revised if needed after each fall. Any discrepancy noted during the audit will be corrected at that time. The audit will take place weekly X 4 weeks, then monthly. The DON will submit results of the audit to the QAPI committee monthly, for its review and recommendations. Date of Compliance: 12/16/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 657	Continued From page 45 (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 9/6/19 coded the resident as being moderately impaired in ability to make daily life decisions. The resident was coded as extensive care for bathing, hygiene, toileting, and dressing; supervision for bed mobility; independent for eating and ambulation; had no upper or lower extremity impairment; was incontinent of bowel frequently and had an indwelling catheter for bladder. A review of the clinical record revealed a nurse's note dated 2/8/19 that documented, "pt (patient) observed on floor stated he slid off bed, Denies pain or discomfort at this time, pt cath (catheter) open, urine on floor, neuro (neurological) check initiated...." A review of the clinical record revealed a nurse's note dated 5/24/19 that documented, "Resident was observed sitting on floor in front of closet with wheelchair next to him. Assessed for injury. Skin tear noted to right elbow. Area cleaned, steri strips applied and covered with border gauze..." A review of the comprehensive care plan failed to reveal any evidence that the care plan was reviewed or revised after either of the above falls . On 11/18/19 at 12:36 PM in an interview with LPN #8 (Licensed Practical Nurse), when asked if a care plan should be reviewed and revised after a fall, she stated it should be. When asked who can update the care plan, she stated the nurses, unit manager, anyone can. On 11/18/19 at 4:51 PM, in an interview with RN #1 (Registered Nurse), when asked if a care plan	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 657	Continued From page 46 should be updated after a fall, she stated it should be. When asked who can update the care plan, she stated, "I assume the unit manager. I have never been told I could update a care plan." A review of the facility policy, "Comprehensive Person-Centered Care Planning" documented, "....15. The Care Planning / Interdisciplinary Team is responsible for the review and updating of care plans; a) When requested by the resident/resident representative; b) When there has been a significant change in the resident's condition; c) When the desired outcome is not met; d) When the resident has been readmitted to the facility form a hospital stay; and e) At least quarterly and after each OBRA MDS assessment." On 11/18/19 at 6:05 PM, ASM #1 (Administrative Staff Member) was made aware of the findings. No further information was provided.	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure professional standards of quality for as needed pain medications for two of 60 residents in the survey sample, Resident #81 and #87. The	F 658	**F 658** It is the practice of this facility that services provided meet professional standards of quality. **I** The orders for Residents #81 and #87 were clarified by the MD to reflect which medication should be given first. **II** The DON/ADON or Unit Managers conducted an audit of residents with PRN pain medication orders to determine if there were any others with orders that needed clarified. Any discrepancy noted during the audit was addressed at that time with notification to the MD or NP and orders clarified.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 658	Continued From page 47 facility staff failed to clarify two PRN (as needed) pain medication orders for Resident #81 to determine when each medication should be administered based on pain level parameters. The facility staff failed to clarify two PRN (as needed) pain medication orders for Resident #87 to determine when to administer each medication based on pain level parameters. The findings include: 1. Resident #81 was admitted to the facility with diagnoses that included but were not limited to: cancer of the lung, anxiety disorder, stroke, chronic pain syndrome, and high blood pressure. The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 11/7/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) scoring, indicating she was capable of making daily cognitive decisions. Resident #81 was coded as requiring limited to extensive assistance for all of her activities of daily living. In Section J - Health Conditions, the resident was coded as having pain occasionally that has made it hard for her to sleep at night. Resident #81 was coded as having limited her day-to-day activities because of pain. The resident coded her pain level as a "7." Zero being no pain and ten as the worst pain you can imagine. The physician orders dated, 10/9/19, documented, "Acetaminophen (Tylenol) (used to treat mild to moderate pain or fever) (1), 325 mg (milligrams); give 2 tablet by mouth every 6 hours as needed for pain." The physician order dated, 11/13/19, documented, "Percocet Tablet 5-325	F 658	III The DON or ADON conducted an in-service for licensed staff on 11/20/2019 or before compliance date regarding: • F 658 Professional standards related to pain management ◦ PRN pain medications • Pre/Post pain scores • Pain scales and pain scoring IV The DON/ADON or Unit Managers will conduct an audit of residents with PRN pain medication to verify that the orders state parameters for when to give the medication. This audit will be conducted weekly X 8 weeks. Any discrepancy in the audit will be corrected at that time with notification to the MD or NP for clarification orders. The DON will submit results of the audit to the QAPI committee monthly for its review and recommendations. Date of Compliance 12/16/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 658	Continued From page 48 MG (oxycodone - acetaminophen- used to treat severe pain) (2) Give 1 tablet by mouth every 4 hours as needed for pain." The November MAR (medication administration record) documented the above physician medication orders. The Acetaminophen was documented as administered on 11/2/19 at 12:35 a .m. for a pain level of "7." The Percocet Tablet was documented as administered on the following dates and times for pain level ratings as follows: on 11/13/19 at 5:15 p.m. for a pain level of "9" and on 11/14/19 at 2:45 a.m. for a pain level of "7." The comprehensive care plan dated, 9/20/19 and revised on 10/10/19, documented in part, "Focus: Pain Management: The resident has potential for pain r/t (related to) Depression, Fibromyalgia." The "Interventions" documented in part, "Administer Percocet as ordered. Offer pain interventions." An interview was conducted with LPN (licensed practical nurse) #4 on 11/13/19 at 3:42 p.m. When asked what staff does when a resident has two as needed pain medications prescribed, LPN #4 stated, "If it's mild pain I would give Tylenol. If it's above a "6" on the pain scale, I'd give the Percocet." When asked if it is with in her scope of practice to make that decision, LPN #4 stated, "Yes, it's in my nursing judgment as to which to give." An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 11/13/19 at 4:02 p.m. When asked how staff know which as needed pain medication to administer if a resident has two as needed pain	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 658	Continued From page 49 medications prescribed, ASM #2 stated, "It's a nursing judgement." When asked if it is within a nurse's scope of practice to decide what to give, ASM #2 stated, "I guess no, it should be the doctors that define which to give." An interview was conducted with ASM # 6, the nurse practitioner, on 11/15/19 at 12:07 p.m. When asked if a nurse can decide which as needed pain medications to give if there is nothing in the orders to tell them when to administer each medication, ASM #6 stated, "We are supposed to ensure that each PRN (as needed) pain medication has numbers of the pain scale [parameters] with each order." The facility policy, "Pain Management" documented in part, "Pain management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals...Specific Procedures/Requirements: f. Identifying and using specific strategies for different levels and sources of pain." ASM #1, the administrator, ASM #2 the director of nursing and ASM #3, the regional vice president of clinical services, were made aware of the above concern on 11/15/19 at 2:00 p.m. No further information was provided prior to exit. References: (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a681004.html. (2) This information was obtained from the	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 658	Continued From page 50 following website: https://medlineplus.gov/ency/article/007285.htm 2. Resident #87 was admitted to the facility on 10/16/18 with diagnoses that include but were not limited to: respiratory failure, chronic pain syndrome, COPD (1) and anxiety disorder. The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 10/24/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. In Section G - Functional Status, the resident was coded as being independent in all of her activities of daily living except bathing in which she required limited assistance. In Section J - Health Conditions, the resident was coded as having pain during the look back period that is "almost constant." She was coded that the pain has made it hard for her to sleep at night. Resident #87 was coded as having pain that has limited her day-to-day activities because of pain. Resident #87 was coded as having a pain level at the time of the assessment as being an "8." The physician orders dated, 4/29/19 documented, "Roxicodone Tablet 5 MG (milligrams) (oxycodone) (Oxycodone is used to relieve moderate to severe pain) (2), Give 1 tablet by mouth every 4 hours as needed for pain." The physician order dated 5/21/19, documented, "Acetaminophen (Tylenol) (used to treat mild to moderate pain and fever) (3) Give 325 MG by mouth every 6 hours as needed for pain do not exceed 3250 mg daily." The October 2019 MAR (medication	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 658	Continued From page 51 administration record) documented the above physician medication orders. The medications were administered on the following dates and times for pain level ratings as follows: Acetaminophen: 10/16/19 at 10:18 a.m. - pain level - 6 10/18/19 at 4:58 p.m. - pain level - 7 Oxycodone: 10/1/19 at 1:15 a.m. - pain level - 7 10/1/19 at 6:16 a.m. - pain level - 7 10/1/19 at 6:20 p.m. - pain level - 6 10/1/19 at 10:20 p.m. - pain level - 6 10/2/19 at 2:24 a.m. - pain level - 8 10/2/19 at 7:40 a.m. - pain level - 6 10/2/19 at 4:05 p.m. - pain level - 6 10/2/19 at 8:40 p.m. - pain level - 6 10/3/19 at 12:40 a.m. - pain level - 8 10/3/19 at 5:00 a.m. - pain level - 8 10/3/19 at 9:15 a.m. - pain level - 7 10/3/19 at 10:45 a.m. - pain level - 6 10/4/19 at 4:59 a.m. - pain level - 8 10/4/19 at 9:41 a.m. - pain level - 8 10/4/19 at 10:28 p.m. - pain level - 6 10/5/19 at 3:00 a.m. - pain level - 8 10/5/19 at 8:20 a.m. - pain level - 6 10/6/19 at 1:19 a.m. - pain level - 7 10/6/19 at 8:31 a.m. - pain level - 6 10/6/19 at 12:29 p.m. - pain level - 6 10/6/19 at 4:45 p.m. - pain level - 6 10/6/19 at 8:47 p.m. - pain level - 6 10/7/19 at 2:17 a.m. - pain level - 7 10/7/19 at 8:32 a.m. - pain level - 6 10/7/19 at 4:48 p.m. - pain level - 7 10/7/19 at 9:17 p.m. - pain level - 6 10/8/19 at 5:47 a.m. - pain level - 8 10/8/19 at 10:16 a.m. - pain level - 9 10/8/19 at 2:42 p.m. - pain level - 8 10/8/19 at 9:25 p.m. - pain level - 6 10/9/18 at 1:44 a.m. - pain level - 7	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 658	Continued From page 52 10/9/19 at 5:54 a.m. - pain level - 7 10/9/19 at 10:23 a.m. - pain level - 8 10/9/19 at 2:51 p.m. - pain level - 7 10/10/19 at 12:00 a.m. - pain level - 8 10/10/19 at 5:15 a.m. - pain level - 7 10/10/19 at 1:33 p.m. - pain level - 6 10/10/19 at 5:27 p.m. - pain level - 7 10/11/19 at 1:30 a.m. - pain level - 8 10/11/19 at 5:33 a.m. - pain level - 7 10/11/19 at 1:33 p.m. - pain level - 6 10/11/19 at 5:36 p.m. - pain level - 7 10/12/19 at 1:25 a.m. - pain level - 7 10/12/19 at 8:44 a.m. - pain level - 7 10/12/19 at 12:51 p.m. - pain level - 7 10/12/19 at 4:58 p.m. - pain level - 7 10/13/19 at 2:30 a.m. - pain level - 8 10/13/19 at 6:32 a.m. - pain level - 8 10/13/19 at 10:37 a.m. - pain level - 7 10/13/19 at 2:54 p.m. - pain level - 8 10/13/19 at 8:47 p.m. - pain level - 8 10/14/19 at 7:57 a.m. - pain level - 7 10/14/19 at 12:00 p.m. - pain level - 6 10/15/19 at 12:00 a.m. - pain level - 8 10/15/19 at 5:30 a.m. - pain level - 8 10/15/19 at 9:30 a.m. - pain level - 6 10/15/19 at 1:30 p.m. - pain level - 6 10/15/19 at 5:50 p.m. - pain level - 6 10/15/19 at 10:07 p.m. - pain level - 6 10/16/19 at 2:18 a.m. - pain level - 6 10/16/19 at 6:46 a.m. - pain level - 7 10/16/19 at 11:54 a.m. - pain level - 6 10/16/19 at 4:27 p.m. - pain level - 6 10/16/19 at 8:44 p.m. - pain level - 6 10/17/19 at 12:45 a.m. - pain level - 8 10/17/19 at 5:45 a.m. - pain level - 8 10/17/19 at 10:16 a.m. - pain level - 7 10/17/19 at 2:45 p.m. - pain level - 7 10/17/19 at 8:28 p.m. - pain level - 6 10/18/19 at 1:15 a.m. - pain level - 8	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 658	Continued From page 53 10/18/19 at 5:40 a.m. - pain level - 7 10/18/19 at 2:-5 p.m. - pain level - 7 10/18/19 at 6:23 p.m. - pain level - 7 10/18/19 at 10:37 p.m. - pain level - 6 10/19/19 at 2:40 a.m. - pain level - 8 10/19/19 at 6:50 a.m. - pain level - 7 10/19/19 at 2:50 p.m. - pain level - 6 10/19/19 at 8:40 p.m. - pain level - 6 10/20/19 at 1:16 a.m. - pain level - 7 10/20/19 at 6:30 a.m. - pain level - 7 10/20/19 at 10:30 a.m. - pain level - 6 10/20/19 at 6:35 p.m. - pain level - 6 10/20/19 at 10:35 p.m. - pain level - 6 10/21/19 at 2:46 a.m. - pain level - 8 10/21/19 at 6:53 a.m. - pain level - 8 10/21/19 at 11:12 a.m. - pain level - 7 10/21/19 at 3:15 p.m. - pain level - 6 10/21/19 at 8:20 a.m. - pain level - 7 10/22/19 at 12:30 a.m. - pain level - 8 10/22/19 at 5:00 a.m. - pain level - 7 10/22/19 at 11:00 a.m. - pain level - 8 10/22/19 at 3:09 p.m. - pain level - 8 10/22/19 at 6:51 p.m. - pain level - 7 10/22/19 at 11:15 p.m. - pain level - 8 10/23/19 at 3:32 a.m. - pain level - 8 10/23/19 at 7:35 a.m. - pain level - 6 10/23/19 at 11:35 a.m. - pain level - 6 10/23/19 at 4:15 p.m. - pain level - 6 10/23/19 at 8:20 p.m. - pain level - 6 10/24/19 at 12:30 a.m. - pain level - 8 10/24/19 at 1:51 p.m. - pain level - 7 10/24/19 at 6:10 p.m. - pain level - 6 10/24/19 at 10:10 p.m. - pain level - 6 10/25/19 at 3:01 a.m. - pain level - 8 10/25/19 at 12:58 p.m. - pain level - 7 10/25/19 at 5:20 p.m. - pain level - 6 10/25/19 at 10:35 p.m. - pain level - 6 10/26/19 at 5:05 a.m. - pain level - 7 10/26/19 at 1:18 p.m. - pain level - 7	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 658	Continued From page 54 10/26/19 at 5:24 p.m. - pain level - 7 10/26/19 at 9:52 p.m. - pain level - 7 10/27/19 at 2:00 a.m. - pain level - 7 10/27/19 at 9:39 a.m. - pain level - 7 10/27/19 at 1:41 p.m. - pain level - 7 10/2719 at 5:56 p.m. - pain level - 7 10/27/19 at 10:45 p.m. - pain level - 7 10/28/19 at 3:00 a.m. - pain level - 8 10/28/19 at 8:43 a.m. - pain level - 7 10/28/19 at 5:55 p.m. - pain level - 6 10/28/19 at 9:55 p.m. - pain level - 6 10/29/19 at 2:00 a.m. - pain level - 8 10/29/19 at 10:00 a.m. - pain level - 8 10/29/19 at 2:01 p.m. - pain level - 8 10/29/19 at 6:02 p.m. - pain level - 6 10/29/19 at 10:02 p.m. - pain level - 6 10/30/19 at 11:16 a.m. - pain level - 7 10/30/19 at 4:18 p.m. - pain level - 6 10/30/19 at 9:00 p.m. - pain level - 6 10/31/19 at 1:02 a.m. - pain level - 8 10/31/19 at 5:15 a.m. - pain level - 7 10/31/19 at 5:28 p.m. - pain level - 6 10/31/19 at 9:30 p.m. - pain level - 6 The November 2019 MAR documented the above physician medication orders. Further review of the MAR revealed the medications were administered on the following dates and time for pain level ratings as follows: Acetaminophen: was not administered. Oxycodone: 11/1/19 at 7:50 a.m. - pain level - 6 11/1/19 at 11:55 a.m. - pain level - 7 11/2/19 at 12:00 a.m. - pain level - 8 11/2/19 at 4:30 a.m. - pain level - 8 11/2/19 at 1:10 p.m. - pain level - 7 11/2/19 at 5:55 p.m. - pain level - 6 11/2/19 at 10:15 p.m. - pain level - 6 11/3/19 at 2:15 a.m. - pain level - 7	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 658	Continued From page 55 11/3/19 at 6:15 a.m. - pain level - 7 11/3/19 at 10:40 a.m. - pain level - 7 11/3/19 at 3:50 p.m. - pain level - 6 11/3/19 at 8:30 p.m. - pain level - 6 11/4/19 at 12:30 a.m. - pain level - 7 11/4/19 at 4:36 a.m. - pain level - 7 11/4/19 at 9:13 a.m. - pain level - 7 11/4/19 at 5:05 p.m. - pain level - 7 11/5/19 at 8:51 a.m. - pain level - 7 11/5/19 at 5:06 p.m. - pain level - 6 11/6/19 at 1:00 a.m. - pain level - 8 11/6/19 at 5:10 a.m. - pain level - 7 11/6/19 at 9:50 a.m. - pain level - 8 11/6/19 at 1:30 p.m. - pain level - 9 11/6/19 at 10:08 p.m. - pain level - 8 11/7/19 at 2:30 a.m. - pain level - 8 11/7/19 at 6:45 a.m. - pain level - 9 11/7/19 at 10:40 a.m. - pain level - 8 11/7/19 at 2:20 p.m. - pain level - 8 11/7/19 at 6:57 p.m. - pain level - 9 11/7/19 at 11:02 p.m. - pain level - 8 11/8/19 at 3:39 a.m. - pain level - 8 11/8/19 at 9:02 a.m. - pain level - 7 11/8/19 at 1:25 p.m. - pain level - 7 11/8/19 at 5:36 p.m. - pain level - 8 11/9/19 at 1:03 p.m. - pain level - 8 11/9/19 at 5:35 p.m. - pain level - 6 11/9/19 at 9:40 p.m. - pain level - 6 11/10/19 at 1:45 a.m. - pain level - 8 11/10/19 at 5:45 a.m. - pain level - 7 11/10/19 at 9:30 a.m. - pain level - 7 11/10/19 at 3:47 p.m. - pain level - 7 11/11/19 at 12:45 a.m. - pain level - 8 11/11/19 at 5:00 a.m. - pain level - 7 11/11/19 at 9:27 a.m. - pain level - 6 11/11/19 at 1:42 p.m. - pain level - 7 11/12/19 at 11:45 a.m. - pain level - 8 11/12/19 at 3:58 p.m. - pain level - 6 11/12/19 at 8:45 p.m. - pain level - 6	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 658	Continued From page 56 11/13/19 at 12:45 a.m. - pain level - 6 11/13/19 at 5:15 a.m. - pain level - 6 11/13/19 at 1:23 p.m. - pain level - 4 11/13/19 at 5:38 p.m. - pain level - 6 11/13/19 at 9:45 p.m. - pain level - 6 11/14/19 at 2:06 a.m. - pain level - 8 11/14/19 at 6:09 a.m. - pain level - 8. The comprehensive care plan dated, 10/17/18 and revised 2/25/19, documented, "Focus: (Resident #87) has chronic pain r/t (related to) osteoporosis, multiple musculoskeletal disorders and COPD." The "Interventions" documented in part, "Administer analgesia as per order." An interview was conducted with LPN (licensed practical nurse) #4 on 11/13/19 at 3:42 p.m. When asked what staff does when a resident has two as needed pain medications prescribed, LPN #4 stated, "If it's mild pain I would give Tylenol. If it's above a "6" on the pain scale, I'd give the Percocet." When asked if it is with in her scope of practice to make that decision, LPN #4 stated, "Yes, it's in my nursing judgment as to which to give." An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 11/13/19 at 4:02 p.m. When asked how staff know which as needed pain medication to administer if a resident has two as needed pain medications prescribed, ASM #2 stated, "It's a nursing judgement." When asked if it is within a nurse's scope of practice to decide what to give, ASM #2 stated, "I guess no, it should be the doctors that define which to give." An interview was conducted with ASM # 6, the nurse practitioner, on 11/15/19 at 12:07 p.m.	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 658	Continued From page 57 When asked if a nurse can decide which as needed pain medications to give if there is nothing in the orders to tell them when to administer each medication, ASM #6 stated, "We are supposed to ensure that each PRN (as needed) pain medication has numbers of the pain scale [parameters] with each order." ASM #1, the administrator, ASM #2 the director of nursing and ASM #3, the regional vice president of clinical services, were made aware of the above concern on 11/15/19 at 2:00 p.m. No further information was provided prior to exit. (1) COPD - Chronic Obstructive Pulmonary Disease is general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis. 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/a682132.html. (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a681004.html.	F 658		
F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §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	F 689	**F 689** It is the policy of the facility that residents who desire to smoke will be allowed to smoke under direct supervision.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 58 §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, resident interview, facility document review, and clinical record review, facility staff failed to ensure six of 60 sampled residents, (Residents #32, #36, #45, #95, #48, and #101) were assessed and safe, for unsupervised smoking, to prevent accidents and injuries, and failed to ensure a safe environment for smoking residents, and others residing in the facility. On 11/12/19, during entrance, the facility administrator, ASM (administrative staff member) #1 stated the facility was a nonsmoking facility and presented the policy. On 11/14/19 at 9:14 a.m., Resident #32 and 36 were observed outside on the south unit, patio (on the facility premises) smoking, without staff supervision. The patio area had no receptacles to safely, extinguish and dispose of cigarettes, or safety equipment (fire extinguishers, fire blankets, etc.). The clinical records for both residents documented noncompliant smoking behaviors, but failed to evidence either resident had been assessed, as safe to smoke unsupervised. On 11/14/19, Residents #45, #95, #48, and #101, were identified as residents who smoke on a list provided by ASM #1, the administrator. Each resident had documented noncompliant smoking behaviors and the facility staff stated they were aware. The clinical records for Residents #45, #95, #48, and #101, failed to evidence they had smoking assessment completed or had been assessed as safe to smoke unsupervised. This resulted in Immediate Jeopardy (IJ) and SQC (substandard quality of care), which was identified in the area of Quality of Care on 11/14/19 at 1:56	F 689	I Residents who are smoking have had a smoking assessment complet4ed immediately. (Residents #45, #101, #32, #36, #95, #48) to determine their ability to smoke safely. Each has been deemed to be able to smoke safely. They will be allowed to smoke with supervision in the designed area. The care plans of each resident were updated. II An audit completed at 2:30pm on 11/14/2019 was conducted to identify other residents who may be smoking without knowledge. Two others were identified. These had smoking assessments completed along with care plan updates. III Smoking Policy has been revised to ensure safe smoking. Residents who smoke will be informed and educated on the new policy. Department managers and Hospitality aides were educated on the new policy. All new admissions will be educated on the new smoking policy and a smoking assessment will be conducted on any resident who desires to smoke to ensure safe smoking.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 59 p.m. The plan of removal for the immediacy was accepted on 11/14/19, at 7:30 p.m. The IJ was abated on 11/15/19 at 10:40 a.m., with the Scope and Severity lowered to Level II, Pattern. The findings Include: Surveyor A: 1. On 11/12/19 at 11:30 a.m., during the entrance conference, the ASM (administrative staff member) #1, the administrator stated that the facility is a non-smoking facility and provided the facility policy asserting the facility's non-smoking status. A review of the facility policy, documented the following: "It is the policy of (name of facility) to be a non- smoking facility for residents. This smoke-free environment is to ensure that the environment exists from threat of Fire and of primary and secondary smoke. No Smoking will not be allowed inside the facility at any time. We do recognize that a resident has the right to smoke and this will be allowed, however they must go off campus. Their lighters must be kept at nurses' station and they must return them after they are finished smoking. The designated area for Visitors is outside at the front porch marked off with yellow tape. Staff members who smoke will only be allowed to smoke outside off the loading dock in the space provided." (Note - a tour of the facility, discussed in a later paragraph, revealed there was no area marked off with yellow tape.) This policy was noted as "Revised October 2019." On 11/14/19 at 9:15 AM, an observation was	F 689	IV A QAPI meeting was held on 11/14/2109 regarding the new smoking policy. QAPI team will review the smoking policy quarterly and provide updates if needed. Date of Compliance: November 15, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 60 made of the South unit, patio area by bending down to look through one of three windows with blinds. The window the observation was conducted through had blinds closed 3/4 the way and revealed two residents [Resident #36 and #32] smoking on the south unit patio (on facility property). Resident #36 was sitting in a chair on the patio alongside Resident #32. Both residents were observed smoking. No staff members were assisting the residents. No safety devices such as a fire extinguisher or smoking aprons were observed in the smoking area. There were no cigarette disposal devices to safely extinguish and dispose of cigarettes. The inside of the building at this patio was the south unit living room / dayroom / dining area. There were three large windows located on the end wall of the building that faced this patio area. Two of the windows hand blinds closed all the way. The third window through which the observation was conducted had the blinds closed 3/4 of the way down. There were two doors, observed that led out from either side of the living room / dayroom / dining area. One door on the left and one on the right side, close to the large windows. Both doors required a keypad code to exit the building. The two residents who were smoking on the patio were not visible through the windows with the blinds all the way down. On one side of the living room / dayroom / dining area, at the last resident room, closest to the windows, LPN (licensed practical nurse) #8 was observed at a medication cart. When asked whom the two residents were outside on the patio, LPN #8 went over to the window through which the observation was made, and moved the blind to the side to see the residents. LPN #8 identified the residents that were smoking as Residents #32 and #36. There was no other staff noted in the area inside or	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 61 outside of the building supervising the two residents. On 11/14/19 at 9:17 AM in an interview with CNA #3 (Certified Nursing Assistant), she was asked if the residents were allowed to smoke there. CNA #3 stated, "I honestly don't know." On 11/14/19 at 9:44 AM, in an interview with ASM #2 (Administrative Staff Member, the Director of Nursing), ASM #2 stated, "This is a non-smoking facility. It was non-smoking before I got here. I started June, 2018." When asked about assessing the residents for safe smoking, ASM #2 stated, "We don't assess them because we are a non-smoking facility." When asked about the location of where residents, are instructed to smoke, ASM #2 stated, "The sign (the property entrance sign that identifies the name of the facility located at the entrance to the parking lot) is off grounds. That is off-site for smoking for (name of facility)." (Note: This sign is located in a mulched roundabout area where the street meets the parking lot. The street extends off the main road and goes up hill towards this mulched area marking the entrance to the facility parking lot) When asked if that is the only place, the residents can smoke, ASM #2 stated, "Yes, to my knowledge." When asked if she had seen residents smoke elsewhere, ASM #2 stated, "No." When asked if residents were assessed to determine if they were safe to smoke in these areas, ASM #2 stated, "No because it is non-smoking facility." When asked about residents who smoke at the facility, ASM #2 stated, "That I'm aware of, maybe five, (she then named the residents, including Resident #32 and #36). ASM #2 was asked when the facility was	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 62 aware the residents were smokers. ASM #2 stated, "I knew they were (smokers) before today." When asked if residents who are smoking should be, care planned, ASM #2 stated, "Yes. Whenever we realize they are a smoker." When asked further about the care plans, as reviews had revealed the care plans were developed and/or reviewed/revised on this date (11/14/19), ASM #2 stated, "I did the care plans this morning, I won't lie to you. I was told you (surveyors) were looking at smokers." When asked who updated the care plans, ASM #2 stated, "I updated all of them." When asked who should have updated them before this date, ASM #2 stated, "I thought social services would have updated the care plan." When asked if the facility has IDT (Interdisciplinary team) meetings, ASM #2 stated, "Yes, I don't attend the meetings." When asked if the facility has weekly care plan meetings, ASM #2 stated, "Yes, if they are not complying (with no smoking) we talk about it as a behavior. To my knowledge this is a non-smoking facility." Resident #32's diagnoses include but are not limited to, stroke with hemiplegia, and seizure disorder. The most recent MDS, an annual assessment, with an assessment reference date coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one staff member for bed mobility, transfers, dressing, and bathing. He required limited assistance of one staff member for toileting and personal hygiene. In Section G - Functional Status, the resident was coded as having impairments in his range of motion in his arm and leg on one side. Resident	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 63 #32 was coded as being independent in moving on and off the unit with only set up assistance. The resident was coded as using a wheelchair for his locomotion. Under J1300, he was coded, "no" for tobacco use. A physician's order dated 4/3/19, documented, "Nicotine Patch 14 mg (milligrams) daily for 2 weeks, and then decrease to 7 mg daily for 2 weeks and then discontinue." A review of the April 2019 MAR (Medication Administration Record) revealed that the patch was provided. The comprehensive care plan dated 3/3/17 documented, "Behaviors: (Resident #32) is aware this is a non smoking (Sic.) facility." The interventions included, "3/3/17 - Encourage pt (patient) not to smoke or ask visitors for cigarettes due to no smoking policy. 3/3/17 - Encourage (Resident #32) to not get cigarettes out of ashtrays out side (Sic.). 3/3/17 - Review smoking policy with resident as needed." There were no other interventions prior to the survey, for smoking. Further review of 6 months of notes in the clinical record revealed the following notes documented by the social worker: On 5/7/19, 5/14/19, 5/21/19, 5/28/19, 6/4/19, 6/18/19, 7/2/19, 7/12/19, 7/16/19, 7/30/19, 8/6/19, 8/14/19, and 8/26/19, that documented, "....(Resident #32) smokes when (Resident #32) knows a family member or friend must be with (Resident #32). (Resident #32) is wearing a nicotine patch, but continues to sneak smoke...." (Note the physician order for the patch was during the month of April. There were no nicotine patch orders in place and no nicotine patch	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 64 provided for the above identified dates.) On 9/4/19 the following was documented, "....(Name of Resident #32) smokes when (Name of Resident #32) knows a family member or friend must be with (Name of Resident #32). (Name of Resident #32) is giving other residents cigarettes. (Name of Resident #32) has been educated. Denies this behavior...." On 9/17/19, 9/25/19, and 10//1/19 the following was documented, "....(Name of Resident #32) continues to smoke when (Name of Resident #32) has been educated on smoking policies. (Name of Resident #32) is providing cigarettes to other residents in the facility, and denies behaviors when questioned...." On 10/22/19, the following was documented, "....Resident continues to smoke when (Name of Resident #32) has been educated on smoking policies. Resident is providing cigarettes to other residents in the facility, and denies giving other residents cigarettes. Resident picking up cigarette butts in the parking lot to smoke. Resident denies this behavior...." On 11/7/19, the following was documented, "....resident continues to smoke when (Name of Resident #32) has been educated on smoking policies. (Name of Resident #32) is providing cigarettes to other residents in the facility, and denies behaviors when questioned. Resident also is picking up cigarette butts in the parking lot...." Review of the clinical record failed to evidence any smoking assessments for safe unsupervised smoking or any other interventions to address the residents continued smoking other than what is	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 65 documented above. Surveyor B clinical record review of Resident #36 and interview: Resident #36, was admitted 2/21/19, diagnoses included but are not limited to, dementia, epilepsy (seizure disorder), and unsteadiness on feet. Resident #36's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 03/01/2019, scored Resident #36 at a 14 on the BIMS (brief interview for mental status), indicating minimal impairment. Resident #36 was coded as requiring supervision of one staff member for most ADLs (activities of daily living). Under J1900. Number of falls since admission or prior assessment, ..whichever is most recent, Resident #36 was coded with a "1" under: B. Injury (except Major) skin tears, abrasion, laceration, superficial bruises, hematomas, and sprains; or any fall -related injury that causes the resident to complain of pain. Resident #36's mobility device was coded as a walker. Resident #36's care plan documented interventions for the behavior of smoking as follows: "Instruct Resident about smoking risks and hazards and about smoking cessation aids that are available", "notify charge nurse immediately if it is suspected that resident has violated facility smoking policy (Non Smoking facility)". These interventions were dated "Initiated 02/22/2019" and "Revised 02/26/2019". On 11/14/2019 at 12:00p.m., an interview was conducted with Resident #36 regarding his smoking habits at the facility. During this interview, Resident #36 stated that on one	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 66 occasion he fell while ambulating himself to the spot staff had directed him to smoke, which was a mulch-covered area near the facility signage (the property entrance sign that identifies the name of the facility located at the entrance to the parking lot). Resident #36 stated that he became weak and "just sort of sat down suddenly". When asked how he got back, Resident #36 stated that another resident who was out to smoke, Resident #32 who uses a wheelchair, had to wheel back to the facility and get staff for assistance. A review of Resident #36's medical record verified documentation of a fall without injury occurring on 09/04/2019. An entry dated 10/02/2019, documented "IDT (interdisciplinary team) met to review fall when legs became weak while walking and he fell. Will continue on therapy caseload and no other falls have been reported. Team will continue to monitor." Resident #36's medical record, failed to evidence a smoking assessment to determine safety smoking and with unsupervised smoking. Surveyor A: On 11/14/19 at 10:12 AM, an interview was conducted with OSM #3 (Other Staff Member, Director of Social Services), regarding residents that smoked. OSM #3 stated, "Usually, if I find out they are smoking, I have to tell them it is a non-smoking facility, which they already know." When asked what that means, OSM #3 stated, "Not to smoke on the grounds." When asked about the location residents are allowed to smoke, OSM #3 stated, "Past the sign in the roundabout off the property, and then the grass is	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 67 off grounds (grass next to the south unit patio that Resident #32 and 36 were observed smoking on.)" OSM #3 was asked what she does when a resident is identified as a smoker, OSM #3 stated, "I let smokers know; they are told it's a non-smoking facility. I've been here a year and they have to turn their lighters back into the nurse, sign themselves out (as leaving the property to go smoke). The sign out book is at the nurse's station; they sign out and get a lighter from the nurse. When asked why the facility has them sign out, OSM #3 stated, "To know they are out of the building and know where they are." When asked who is responsible for the residents once they are off the premises, OSM #3 stated, "They are responsible for themselves." When asked about residents who have walkers or wheelchairs going out to the sign at the roundabout located at the top of a hill, OSM #3 stated, "I don't personally think it's safe." When asked if residents are able to smoke without an assessment, OSM #3 stated, "They (residents) shouldn't be smoking." When asked if the facility care plans smoking for residents, OSM #3 stated, "Yes and we discuss it in care plan meetings." When asked what non-compliant means, OSM #3 stated, "Being caught smoking on premises." When asked if the facility expects residents that are noncompliant with smoking to continue being noncompliant, OSM #3 stated, "yes." OSM #3 was asked what the facility has done to ensure the safety of noncompliant smoking residents, OSM #3 stated, "Taking their lighters." When asked if staff is aware residents are not to smoke on the premises and what they are supposed to do if they see residents smoking, OSM #3 stated, "Tell the manager." When asked about safety concerns for noncompliant residents	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 68 smoking on the premises, OSM #3 stated, "Second hand smoke, it is unhealthy. I don't think they're going to burn themselves." When asked if the risk of burning themselves should be assessed, OSM #3 stated, "Yes." OSM #3 was asked if any residents on oxygen smoke. She identified one resident (Resident #95 see write up below). When asked if there was any special education done regarding smoking with the use of oxygen, OSM #3 stated, "Yes, not to smoke with oxygen." OSM #3 stated, "(ASM #1, the Administrator) sent a letter out for our Christmas Party and it included something about the smoking. When asked where the staff smoke, OSM #3 stated, "Off the loading dock by kitchen." When asked if this area is on the premises, OSM #3 stated, "Yes." Note: The above referenced Christmas letter, dated 10/30/19, included a paragraph about smoking. This paragraph documented, "The second item that you end to be aware of has to do with smoking. (Name of facility) is a non-smoking facility for the residents; however, we do recognize the fact that they do have the right to smoke. It is our policy to allow them to smoke off premises. The resident can not (sic) have a lighter or matches in their possession. If they chose (sic) to smoke these items must be kept at the nurse's station and they must sign themselves out and in when leaving to smoke and return these items. Visitors are not allowed to give smoking materials to a resident. If you have concerns regarding the smoking policy, please feel free to contact me." The Administrator signed this. On 11/14/19 at 10:45 AM, a premises tour to	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 69 assess designated smoking areas was conducted with OSM #3. The tour began by exiting from the front doors, walking to the end of the sidewalk that went towards the north end of the building to the left when exiting the front doors. There were two ramp-like areas off the sidewalk to the parking lot along the sidewalk. Once past the parking lot, a roundabout area was mulched in with a curb all the way around it. A sign for the facility was positioned in the mulched area on the side facing the street, away from the parking lot. There were several cigarette butts observed in the mulched area. There was no cigarette disposal device located in this area. OSM #3 stated that the area below the sign, which was at the top of a hill, was designated as off premises where residents could smoke. This area was noted to be a hill that sloped down the street. Proceeding back towards the facility towards the south unit patio, multiple cigarette butts were observed throughout the parking lot. At the second column from main entrance, a plastic/fiberglass trashcan was observed with several small black cigarette butt marks on the outer covering of the trashcan. The patio area off the south unit was observed next (when exiting the building from the main entrance, this patio area would be to the far right of the building.) There was no cigarette disposal device located there. There was a couple of seating chairs and rocking chairs. There were dried leaves the on patio next to brick building. There was no sidewalk access directly to this patio area from the main entrance. Residents would have to go across the parking lot and a grassy area. OSM #3 stated that the residents are to smoke off the patio area (in the grassy	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 70 areas that surrounded the patio on three sides) which is at the top of the hill. The grassy area off the front of the patio sloped downwards. The slope was noted to begin nearly immediately when stepping off the patio area. There was no flat area of grass. To the side of the patio (opposite side of the parking lot), was a tree, with an area that was very small and rocky. The two doors from either side of the south unit living room / dayroom / dining area that lead to this patio were noted to have no means from the outside to reenter the building. The doors required a keypad code to get out and there was no key pad on the outside to get back in. (This was the patio area noted earlier where Residents #32 and #36 were seen smoking.) None of the designated smoking areas for residents was noted to be a level, for residents with walkers, wheel chairs, or unsteady balance at risk of falling. None of the designated smoking areas contained a cigarette disposal device or emergency equipment in the event of a fire such as fire extinguishers and fire blankets. The patio area had no means to regain quick entrance into the facility in the event of a problem. The area by the roundabout required residents to transverse a parking lot and/or sidewalk, both of which were on a slight uphill slope, to regain entrance to the building at the main entrance. The roundabout area was not in sight of facility staff unless the staff was outside the building on the sidewalk. The patio area was in sight of facility staff if the blinds to the windows were open and staff happen to be on that end of the unit at the time. On 11/14/19 at 11:12 AM, an interview was conducted with LPN (licensed practical nurse) #9, regarding where the residents smoke. LPN #9 stated, "There is supposed to be a smoking area but I don't know where they (residents) go."	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 71 When asked about the resident's smoking materials, LPN #9 stated, "I was told they are allowed to keep their cigarettes but the lighters are in the med [medication] room." When asked if any residents have had an incident or injuries from smoking, LPN #9 stated she was not aware of any. When asked if the facility completes assessments to determine safe unsupervised smoking, LPN #9 stated, "They have not been done." LPN #9 then stated, "To my understanding the patio area is a smoking area (south unit patio which is on the facility premises)." LPN #9 stated, "It alarms me. There is nobody out there. I don't know what they do with these cigarettes." When asked if staff are responsible for residents smoking out on the patio area, LPN #9 stated, "That is a good question. It is on the property. We should be (responsible)." When asked if she supervises a resident out on the patio, when she sees them smoking, LPN #9 stated, "No. I am constantly going." When asked if there were any supplies and equipment to ensure the residents safety, like a smoking apron, ashtrays to extinguish cigarettes, LPN #9 stated, "Not to my knowledge." On 11/14/19 at 11:30 AM, in an interview with ASM #1, the Administrator, when asked about the location of designated smoking areas for residents, ASM #1 stated, "They can go out by the sign, and by the back of building patio area." ASM #1 stated, "The ombudsman said the residents have right to smoke. They can go to edge of the patio (south unit patio) on the grass to smoke 25 feet from the building. This comes from State Fire Marshal's office." When asked if the grassy area by the patio was level, ASM #1 stated, "Yes." When asked if that was facility property, ASM #1 stated, "I can't answer that, but	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 72 I think that once you get off the sidewalk it's not our property [no sidewalk was noted that connects the front door to the south unit, patio, only the parking lot]." When asked about the area by the sign, ASM #1 stated, "If they can walk down there and wheel their chairs down there, I would think it is ok." When asked if the identified sign area is at the top of a hill, ASM #1 stated, "I wouldn't call it a hill, I would call it an incline." When asked if residents are at risk of rolling down the hill, ASM #1 stated, "Yes." When asked about the facility's responsibility for the safety of the residents, ASM #1 stated, "We do have responsibility when they are in our facility, but when they do something that is not compliant, then no." When asked about the facility policy for non-smoking, with designated smoking areas, ASM #1 stated, "I've checked with the state ombudsman. I've thought about discharging them (residents that smoke), but the state ombudsman said it was their right." When asked if the fact that residents are non-compliant with their smoking policy relieves the facility from ensuring a safe environment for all residents and ensuring the safety of residents that smoke, ASM #1 stated, "Yes, I do. Before we designated a smoking area, they were smoking everywhere." When asked if she expected the residents to sign out, ASM #1 stated, "I've told them to, I don't check this." When asked why the residents need to sign out, ASM #1 stated, "So we know they are going to be gone." When asked about one resident being responsible for another resident, ASM #1 stated, "No resident should be responsible for another resident, but if the resident wants to do that -that is their right." On 11/14/19 at approximately 9:55 a.m., the survey team requested a list of residents who	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 73 smoke from ASM (administrative staff member) #1, the administrator. At 10:35 a.m., ASM #1 provided a list of seven residents. Review of the clinical records revealed documentation of noncompliant smoking behaviors for six of these seven residents [the seventh newly admitted resident had a smoking assessment completed], (Residents #32, #36, #45, #95, #48, and #101), but failed to evidence the residents, had been assessed for smoking or assessed as safe to smoke unsupervised. The facility had no system for assessing the safety of residents who smoked and no system for providing supervision necessary to keep residents safe and failed to implement consistently their own smoking policy, resulting in a situation with the likelihood for serious harm and injury and the findings of immediate jeopardy with substandard quality of care. The findings of Immediate Jeopardy and substandard quality of care were confirmed on 11/14/19 at 1:26 p.m., during a phone call with the State Agency. On 11/14/19 at 1:56 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3 the regional vice president of clinical services were informed of the Immediate Jeopardy and subsequent SQC (substandard of care), finding and the needed to complete a plan of removal. On 11/14/19 at 7:40 p.m., ASM #1 presented an acceptable plan of correction. Plan of Correction: 1. Residents who are smoking have had a smoking assessment completed immediately. (Residents # 32, #36, #45, #48, #95, and #101) to determine their ability to smoke safely. Each had been deemed to be able to smoke safely. They	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 74 will be allowed to smoke with supervision in the designated area. The care plans were updated. 2. An audit completed at 2:30 p.m. on 11/14/19 was conducted to identify other residents who may be smoking without knowledge. Two others were identified. These had smoking assessments completed; along with care plan updates. 3. Smoking Policy has been revised to ensure safe smoking. Residents who smoke will be informed and educated on the new policy. Department managers and Hospitality aides will be educated on the new policy. 4. A QAPI meeting was held regarding the new policy. A QAPI team will review the smoking policy quarterly and provide updates if needed. 5. November 15, 2019 (Compliance date). The revised smoking policy documented in part: "It is the policy of this facility to establish and maintain safe resident smoking practices. Residents will smoke under direct supervision of a staff member. Prior to, or upon admission, residents shall be informed that smoking is not permitted inside of the facility, but in the outside designated areas only. Policy Interpretation and Implementation Smoking Area: 1. The designated smoking area is located at the back of the facility, within the brick walls of the patio. 2. Indoor smoking is prohibited and all such rules, as they may apply, shall be strictly enforced. Smoking containers 1. Smoking chimney containers shall be available in designated smoking areas. 2. Cigarette butts will be placed in these containers. There is also a fire blanket and fire extinguisher available in the designated smoking area. Smoking Restrictions 1. The Attending Physician, Administrator and Director of Nursing Services (DNS) shall have the	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 75 authority to make the determination as to what restrictions, if any, will need to be placed on the resident's smoking privileges. 2. Any restrictions placed on smoking privileges shall be noted on the care plan so that all personnel may be aware of smoking restrictions. 3. Smoking restrictions may be imposed on residents at any time if the Attending Physician, Administrator, and/or Director of Nursing determine that the resident is not able to smoke safely. 4. Smoking restrictions (such as need for smoking apron, or specific scheduled smoking times), shall not be assessed against any resident for the mere convenience of the staff, but for the safety and well-being of the resident. 5. Residents with smoking privileges will be discouraged from smoking outside during inclement weather including storms and temperature extremes. 6. Residents will be encouraged to wear appropriate clothing for the season and weather conditions when going outside to smoke. Review of Smoking Restrictions: 1. Smoking privileges shall be reviewed at least quarterly via smoking assessment by the Interdisciplinary Team. 2. All smoking privileges shall be so noted on the care plan. 3. Reclassifications of restrictions deemed necessary for the safety and well-being of the resident may be made at any time by the Attending Physician, Administrator, and/or Director of Nursing Services. Safety with oxygen: At no time shall oxygen be permitted to be in use, to include oxygen not turned on, in the smoking area. Smoking Times & assistance with smoking: 1. Residents will be allowed to smoke during specific smoking times under supervision. Smoking times will be from: 6:30-6:45 AM 9:30-9:45 AM 1:30-1:45 PM	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 76 6:30-6:45 PM 2. Residents will be allowed to smoke, in the designated smoking area, during scheduled times with their family member or visitor. The family member/visitor must agree to stay with the resident during the entire smoking period and follow smoking restrictions as identified and care planned for the resident. Family members or visitors may not supervise other residents to smoke at off-scheduled times. 3. Staff members will assist residents in/out of the facility to the smoking area and will have a communication device to use to call for assistance if any is needed. Smoking Articles: Residents shall not be permitted to retain any types of smoking articles, to include cigarettes, tobacco, lighters, matches, etc., either on his/her person or within his/her living or sleeping area, at any time. Purchasing of Smoking Articles for Residents: Staff members and volunteer workers shall be prohibited from purchasing any smoking articles for residents and bringing them to the resident unless approved by the facility Administrator or Director of Nursing. Periodic Checks for Smoking Articles: 1. This facility shall have the authority to make periodic checks to determine if residents have any smoking articles, on their person or in their room, that are in violation of our smoking policy. 2. Articles found shall be given to the Charge Nurse who in turn will store them for the resident and shall make appropriate documentation in the resident's medical record of such articles found and removed. 3. Residents shall be informed, by the person(s) removing such articles, as to why the articles are being taken, and shall do so in a courteous manner. It must be remembered that safety is of the primary concern and that smoking privileges are not being withheld from the resident. 4. Failure to comply with the smoking	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 77 policy may result in a 30-day discharge notice .... Policy Revised 11/14/19" On 11/15/19, the plan of removal was verified by the surveyor's onsite. The education completed by the administration regarding the new smoking policy and procedures was verified. Interviews were conducted with the staff documented in the plan of correction, and additional staff including nursing and certified nursing assistants. All staff interviewed properly stated the revised smoking policy. Observation was made of the new designated smoking area and three of nine residents, identified as smokers were observed during the scheduled smoking time on 11/15/19 at 9:30 a.m. Staff supervised all residents during smoking and all safety measures were in place. The Immediate Jeopardy was abated at 10:40 a.m.11/18/19 11:50 AM, an interview was conducted with ASM #6 (Administrative Staff Member, the Nurse Practitioner) ASM #6 regarding Resident #32 smoking. ASM #6 stated that she was aware that Resident #32 smoked and that (Resident #32), was offered a nicotine patch. On 11/18/19 at 2:30 PM, an interview was attempted with Resident #32. Resident #32 was in bed watching television. Resident #32 was difficult to communicate with due to the effects of a stroke. Resident #32 was able to point to things, and indicate yes and no. Other spoken words were more difficult to understand. During the interview, Resident #32 indicated through yes and no questions, that (Resident #32) had been instructed that the facility was a non-smoking facility but (Resident #32) wanted to smoke anyway and was not going to give up smoking.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 78 Surveyor B Interviews: On 11/14/2019 at 3:35p.m., an interview was conducted with Resident #36 regarding his smoking habits. Resident #36 was asked how often he smoked, and replied that he smoked about three times per day. When asked where he smoked, Resident #36 stated "usually the back patio". When asked if any staff ever went with him or other residents when they smoked, Resident #36 stated "no". When asked where he kept the smoking supplies, Resident #36 stated that he kept his cigarettes in his bedside table, and the staff kept his lighter. When asked how long he has been smoking, Resident #36 stated "all my life". On 11/14/2019 at 4:12p.m., an observation was again made of Residents #36 and #32 on the back patio (on facility property) smoking unsupervised. A cigarette disposal device was now in place. There were no smoking aprons or fire extinguishers visible in the area. On 11/14/2019 at 4:15p.m., two staff members, Registered Nurse (RN) #1, the Assistant Director of Nursing, and Other Staff Member (OSM) #17, the Activities Director, came outside and informed the residents that they could no longer smoke on the patio. RN #1 and OSM #17 escorted the residents back into the building then out another door to a new smoking area. The staff members directed this surveyor's attention to a nearby fire extinguisher and fire blanket in cases attached to the wall. Several cigarette disposal units were also noted in the new smoking area. A review of the facility sign-in and sign-out book revealed Resident #32 signed out only one time	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 79 in November on 11/1/19. Resident #36 had no sign out entries documented for November 2019. On 11/14/19, as documented above, both residents were observed outside smoking unsupervised twice. Surveyor A: 2. The facility staff failed to ensure Resident #45 was assessed and safe for unsupervised smoking. Resident #45 was not observed smoking, however, during an interview on 11/14/19 at 8:55 AM, Resident #45 stated she does go outside to smoke about twice a day with another resident. Resident #45 stated the other resident pushes her in the wheel chair to the smoking area. A review of the clinical record revealed the facility's knowledge of Resident #45 smoking. Resident #45 was admitted with the diagnoses, including but not limited to diabetes, macular degeneration, vascular dementia, peripheral vascular disease, anxiety disorder, depression, and chronic obstructive pulmonary disease. The quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 9/25/19, coded the resident as cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive assistance for transfers, locomotion, dressing, toileting, and hygiene; limited assistance for bed mobility and bathing; as independent for eating and as continent of bowel and bladder. A review of the clinical record failed to reveal any orders for a nicotine patch.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 80 The comprehensive care plan dated 11/10/15, documented, "Cardiac - The resident has coronary artery disease (CAD) r/t (related to) Atrial Fibrillation, Hypertension, smoking." This care plan included the intervention dated 1/20/19, "Encourage resident to refrain from smoking." There was no other interventions for this resident regarding smoking in her care plan prior to the survey. Review of the clinical record revealed the following notes: A note written by ASM #2 the Director of Nursing, dated 2/5/19, that documented, "IDT members met to review residents non compliance with facility smoking policy. (Resident #45) has been made aware several times this is a non smoking facility. The only way (Resident #45) can smoke is with a family member or a friend. Resident continues to go smoke on own. Has been re-educated over and over by staff member. Will continue to monitor." Social worker notes dated 4/10/19, 4/16/19, 4/23/19, 8/15/19, 8/26/19, documented, "....(Resident #45) continues to smoke , (Resident #45) is aware this is a non smoking facility and is not to be smoking without a family member or a friend accompanying (Resident #45)...." Social worker notes dated, 8/15/19, 8/26/19, 9/4/19, 9/10/19, 9/17/19, 9/25/19, 10/1/19, 10/27/19, 10/27/19, 10/29/19, and 11/7/19, all documented, "....(Resident #45) continues to smoke , (Resident #45) is aware this is a non smoking facility and is not to be smoking without a family member or a friend accompanying (Resident #45). She will get another resident to	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 81 take her off the facility premises to smoke...." Review of the clinical record failed to reveal any evidence an assessment for safe unsupervised independent smoking for #45. On 11/14/19 at 11:12 AM, an interview was conducted with LPN #9 (Licensed Practical Nurse) the nurse for Resident #45. LPN #9 stated that the resident [Resident #45] goes out to smoke once or twice a day. When asked where the residents smoke, LPN #9 stated, "There is supposed to be a smoking area but I don't know where they go." On 11/18/19 at 2:01 PM, in an interview with ASM #2, the director of nursing, she stated that the resident had just started smoking a few months prior to the survey [note the IDT note above was dated, 2/5/19]; that the resident had not always smoked at the facility. When asked what was done to address the resident's smoking, ASM #2 stated the social worker talked to (Resident #45) but that was about it. ASM #2 stated that the resident has a mind of (Resident #45) own and is not usually compliant. On 11/18/19 at 2:20 PM in a phone interview with ASM #5 (Administrative Staff Member) the resident's physician, he stated that he was aware at the beginning of the year that the resident started smoking. ASM #5 stated that he spoke with the resident about a nicotine patch and that Resident #45 stated she intended to continue to smoke, so he did not order a patch, in order to prevent over-dosing (Resident #45) with nicotine, which he stated could kill the resident. ASM #5 stated that he was not in agreement with the facility supporting smoking.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 82 ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the vice president of clinical services, were notified of the above concern during the Immediate Jeopardy on 11/14/19 at 1:56 p.m. 3. Resident #95 was admitted to the facility on 4/20/19, diagnoses include, but are not limited to, COPD (chronic obstructive pulmonary disease) (1), congestive heart failure (2), and high blood pressure. On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 10/27/19, Resident #95 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). Resident #95 was coded as being independent for transfers, locomotion on and off the unit, dressing, eating, and toileting. The resident was coded as requiring staff assistance for personal hygiene and bathing. Resident #95 was coded as using a walker for mobility and as using oxygen each day during the look back period. During the course of the survey, Resident #95 was observed multiple times (11/14/19 at 4:05 p.m., 11/14/19 at 6:05 p.m., 11/15/19 at 10:15 a.m., and 11/18/19 at 11:25 a.m.). On each of these observations, Resident #95 was observed lying in her bed with oxygen being delivered at 2 lpm (liters per minute) through a nasal cannula. On each observation, Resident #95 was alert and watching television. A review of Resident #95's social services notes revealed the following entries:	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 83 A note dated 9/10/19, documented, in part: "IDT (interdisciplinary team) members met to review residents (sic) behaviors of this past week, resident is aware she lives in a smoke-free facility. She goes outside on front patio and smokes. IDT members will continue to monitor." The social services director, OSM (other staff member) #3, wrote this note. A noted dated 9/17/19, documented, in part: "IDT members met to review residents (sic) behaviors of this past week, resident is aware she lives in a smoke-free facility. She continues to go outside north wing entrance to smokes (sic)...IDT members will continue to monitor." The social services director, OSM (other staff member) #3, wrote this note. A note dated 9/25/19, documented, in part: "IDT members met to review residents (sic) behaviors of this past week, resident is aware she lives in a smoke-free facility. She continues to go outside north wing entrance to smokes (sic)...IDT members will continue to monitor." The social services director, OSM (other staff member) #3, wrote this note. A note dated 10/1/19, documented, in part: "IDT members met to review residents (sic) behaviors of this past week, resident is aware she lives in a smoke-free facility. She continues to go outside north wing entrance to smokes (sic)...IDT members will continue to monitor." The social services director, OSM (other staff member) #3, wrote this note. A note dated 10/2/19, documented, in part: "Family Meeting - A family meeting was held this morning with resident's son POA (power of	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 84 attorney). In attendance was Son, SW (social worker), DON (director of nursing) and UM (unit manager). We discussed with son .... and she is also being non-compliant with our smoking policy. Son reports this is nothing new for his mother, and that these behaviors have been going on for years due to her depression. We told him that we just wanted to make him aware of the issues ...." The social services assistant, OSM #9, wrote this note. A note dated 10/30/19, documented, in part: "Resident reviewed in care plan meeting for a quarterly review. Resident invited during interview and declined. Family invited by mail on 10/2/19...No one chose to attend at this time. Goals and approaches reviewed. Continue with current plan of care." The social services assistant, OSM #9, wrote this note. A review of Resident #95's comprehensive care plan dated 4/22/19, updated on 9/13/19, and in effect on 11/12/19 when surveyors entered the facility revealed, in part, the following: "SMOKER - The resident has a history of smoking. [Resident #95] will not smoke through the review date...Continue to educate and remind resident this is a nonsmoking facility (date initiated 9/13/19). Instruct resident about the facility policy on smoking: no smoking facility...Notify charge nurse immediately if it is suspected resident has violated facility smoking policy." A review of the physician /NP (nurse practitioner) orders for Resident #95 revealed no evidence of information or medications related to smoking or smoking cessation. A review of Resident #95's Leave of Absence	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 85 Record revealed two entries (5/20/19 at 6:41 p.m. and 5/21/19 at 7:15 p.m.) in which the resident signed herself out. She did not sign herself back in on both dates, and no reason was given for the resident's leave. Further review of Resident #95's clinical record failed to evidence any smoking assessments or that Resident #95, had been assessed as safe to smoke unsupervised prior to survey entrance on 11/12/19. Further review of nurses' notes for Resident #95 revealed no mention of Resident #95's smoking. A review of the physician notes for Resident #95 revealed two notes written by ASM (administrative staff member) #4, the attending physician. ASM #4 wrote notes on 6/30/19 and 9/20/19. On both notes, ASM #4 listed "history of tobacco abuse" as a problem, but did not mention it in the remainder of either note. A review of the nurse practitioner notes Resident #95 dated 5/29/19,6/3/19, 7/24/19, 7/26/19, 8/7/1/9, 8/12/19, 8/14/19, and 10/4/19 revealed no mention of Resident #95's history of tobacco abuse or smoking at the facility. On 11/14/19 at 9:44 a.m., ASM #2, the director of nursing, was interviewed. ASM #2 stated the facility is a non-smoking facility. When asked what is done to assess residents for safe unsupervised smoking, ASM #2 stated, "We don't assesses because we are a non-smoking facility." ASM #2 stated that, to her knowledge, the only place residents could smoke would be off grounds. When asked if a resident who is noncompliant with the non-smoking policy should	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 86 be care planned for noncompliance, ASM #2 stated, "Yes." When asked if Resident #95 is a current smoker, ASM #2 stated, "Yes." On 11/14/19 at 10:12 a.m., OSM #3 social services director, was interviewed. OSM #3 stated Resident #95 is noncompliant with the policy. When asked if any residents who smoke also use oxygen, OSM #3 stated that Resident #95 uses oxygen and smokes. When asked if she has provided any education to Resident #95 related to the oxygen use, OSM #3 stated, "Yes, they know not to smoke while they are using oxygen." When asked if noncompliant residents are being supervised while they smoke, OSM #3 stated, "No." When asked how she knows that Resident #95 is not using oxygen while she is out smoking, OSM #3 did not provide an answer. On 11/14/19 at 11:30 a.m., ASM #1, the administrator, was interviewed. When asked if she is aware that residents are non-compliant with the facility's non-smoking policy, ASM #1 stated, "Yes." On 11/14/19 at 4:05 p.m., Resident #95 was interviewed. When asked if she smokes at the facility, Resident #95 stated, "Yes. Not every day, but most days." When asked where she goes to smoke, Resident #95 stated, "I go outside those doors there [pointing to the doors near the nurse station]." When asked if she goes off the facility property, Resident #95 stated, "No, I just go down the sidewalk a little bit." When asked if she does anything with her oxygen while smoking, Resident #95 stated, "Oh, I take it off. It never leaves the room with me." Resident #95 stated she ambulates independently with her walker, and that no one accompanies her. Resident #95	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 87 further stated, "I don't need anybody. It's not too far to walk." When asked if there was a cigarette disposal device where she had been smoking, Resident #95 stated, "No." When asked how long she has been smoking at the facility, Resident #95 stated, "Ever since I got here. But I only got caught doing it a little while ago." When asked where her smoking materials are kept, Resident #95 stated, "They are right there [pointing a bag hanging on her walker]." When asked if she had both her cigarettes and lighter in her room in the bag, Resident #95 stated, "Yes." At this time, the surveyor approached LPN (licensed practical nurse) #10 and informed her that Resident #95 had reported that she has both cigarettes and a lighter in her room, where there is also an oxygen concentrator. LPN #10 stated, "She is not allowed to have her lighter. I will go get it." On 11/14/19 at 6:11 p.m., an interview was conducted with LPN #10 to verify that Resident #95's lighter was no longer in the room with the oxygen concentrator. LPN #10 showed the surveyor the lighter, and stated, "She [Resident #95] gave it up easily. She knew she was not supposed to have it in there with her." LPN #10 was asked when she became aware that Resident #95 was smoking on facility premises. LPN #10 stated, "I'm not even sure. Not too long ago. It seems like everybody just knew it." When asked if she reported the smoking to anyone, LPN #10 stated, "I'm pretty sure I told the social worker." On 11/18/19 at 10:19 a.m., OSM #9, the social services assistant was interviewed. When asked when she became aware that Resident #95 was smoking outside on the facility premises, OSM #9, stated, "I was not aware until somebody told	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 88 me they had seen her outside smoking, maybe two months ago. I called her son to find out if they were bringing her cigarettes, and he said no. He said she had been a smoker at the assisted living where she lived before this nursing home. He said he had no idea how she was getting her cigarettes. When I found out she (Resident #95) was smoking, I asked her to give me the cigarettes and the lighter. She gave them to me without any trouble. She would typically smoke before I get here or after I leave. My understanding is that she would go outside, down the sidewalk a little ways." When asked if that location was considered to be off facility property, OSM #9 stated, "No." She further stated, "She [Resident #95] is a night owl. She stays up all night and sleeps during the day." OSM #9 stated the administrator and all the department heads are aware that Resident #95 has been smoking. OSM #9 stated this concern was brought up at the daily morning meeting on several occasions. When asked if the attending physician or NP (nurse practitioner) are aware of the smoking, OSM #9 stated, "They are both aware." On 11/18/19, an interview was conducted with OSM #3, at 10:43 a.m. OSM #3 stated that OSM #9, (the social services assistant) was the social worker responsible for Resident #95's unit and that she (OSM #3) attends the IDT meetings and documents those. OSM #3 stated she became aware that Resident #95 was smoking at the facility by going to the north end patio to smoke. She stated, as far as she knew, Resident #95 had never gone off the property to smoke. On 11/18/19 at 11:23 a.m., ASM #4, the attending physician, was interviewed. When asked if he was aware that Resident #95 had been smoking	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 89 at the facility prior to surveyor entrance on 11/12/19, ASM #4 stated, "I don't remember specifically what I knew." On 11/18/19 at 11:49 a.m., ASM #6, the NP (nurse practitioner) was interviewed. When asked if she was aware that Resident #95 had been smoking at the facility, ASM #6 stated, "Yes. I have been aware, but I've actually never seen her smoke. ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the vice president of clinical services, were notified of the above concern during the Immediate Jeopardy on 11/14/19 at 1:56 p.m. References: (1) COPD is "a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis." Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) "Heart failure is a condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body...As the heart's pumping becomes less effective, blood may back up in other areas of the body. Fluid may build up in the lungs, liver, gastrointestinal tract, and the arms and legs. This is called congestive heart failure." This information is taken from the website https://medlineplus.gov/ency/article/000158.htm 4. Resident #48 was admitted to the facility on 3/30/18 with diagnoses that included but were not limited to: Alzheimer's (1), schizophrenia (2) and	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 90 depressive disorder (3). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 9/23/19, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. The resident was coded as independent for bed mobility, transfer, walking in room and corridor, locomotion on and off the unit, dressing, eating, toilet use and personal hygiene. The annual MDS (minimum data set) assessment with ARD (assessment reference date) of 3/23/19 coded the resident's current tobacco use, as "yes". The care plan dated 2/6/19, documented in part, Focus: "Smoking: Non-compliant with smoking policy." The Goal: dated 2/6/19, documented, "(Resident #48) will not smoke against facility policy through next review." The Interventions: dated 2/6/19, documented, "Remind her that she cannot smoke under the breezeway close to front doors and remind her that she may only smoke within the designated area on the front SW (south wing) patio and with family." A social service's note dated 2/12/19 at 11:04 AM, documented in part, "IDT (inter-disciplinary team) members met to review resident's behaviors of this past week, (Resident #48) smokes, she is aware this is a non-smoking facility and is not to be smoking without a family member or friend accompanying her. She is also aware her family does not want her smoking. Team will continue to monitor." Review of the clinical record failed to evidence any smoking assessment or that Resident #48 had been assessed as safe to smoke	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 91 unsupervised. On 11/14/19 at 3:45 PM, an interview was conducted, with Resident #48 regarding smoking. Resident #48 stated, "I've smoked for about 40 years. I was smoking about 1.5 packs per day; I don't smoke that much now." When asked where she goes to smoke at the facility, Resident #48 stated, "I go to the south patio to smoke." When asked if any staff member had discussed smoking with her, Resident #48 stated, "Yes, they told me I could only smoke in designated areas off premises." When asked where those areas were located, Resident #48 stated, "The far side of the sign and the patio." When asked about the residents smoking materials, Resident #48 stated, "I keep the cigarettes, I give them my lighter." When asked if anyone goes out with her to smoke, Resident #48 stated, "I sometimes push (Resident #45) out to smoke with me." When asked if staff had assessed her for risks related to smoking, such as fire, Resident #48 stated, "Today, but I don't remember before that." On 11/14/19 at 4:10 PM, Resident #48 was observed smoking on the South unit, patio (on the facility premises). There were no staff present, no safety equipment such as a fire blanket or extinguisher and no communication method present during this time. A cigarette disposal unit was observed. An interview was conducted with Resident #48 at this time. When asked where she disposed of the cigarette butt, Resident #48 stated, "I put it in the trash can." Resident #48 then placed her cigarette butt in the trashcan, located by the second column from facility front entrance. At this time observation of the trashcan revealed several small black cigarette butt marks on the outer covering. The contents included: a	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 92 plastic trashcan bag, two cigarette butts, one napkin, one empty plastic water bottle, one small plastic bag, one small water cup, one empty Gold colored Marlboro cigarette pack. A review of the "Out on Leave Release of Responsibility of Absence" document for Resident # 48 revealed one sign out for each of following months February 2019, March 2019, May 2019, June 2019, July 2019, August 2019 and October 2019; two sign outs for April 2019 and November 2019. In the month of September 2019 there were 25 sign outs to smoke. ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the vice president of clinical services, were notified of the above concern during the Immediate Jeopardy on 11/14/19 at 1:56 p.m. References: (1) Alzheimer's Disease is progressive loss of mental ability. This information was obtained from Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 25. (2) Schizophrenia is mental disorder characterized by gross distortions of reality, withdrawal from social contacts, and disturbances of thought, language and perception. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 518. (3) Depressive disorder is a dejected state of mind with feelings of sadness, discouragement, and hopelessness. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 157. 5. Resident #101 was admitted to the facility on	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 93 6/3/19 with diagnoses that included but were not limited to: dementia, depression, anxiety disorder, insomnia, restless leg syndrome, muscle weakness and history of falling. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 10/30/19, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. The resident was coded as being independent for walking in the room, locomotion on and off the unit, dressing, eating, toileting, and personal hygiene. Some of these activities required set up assistance prior to independence. The resident was coded as requiring limited assistance for moving in the bed, transfers and walking in the corridor and required extensive assistance for bathing. In Section G0400 - Functional Limitations of Range of Motion, the resident was coded as not having any impairments. The resident's mobility devices was coded as using a wheelchair and walker. A social services note dated, 10/21/19 at 3:09 p.m. documented, "Talked to (name of daughter of Resident #101) and responsible for (Resident #101), that (Resident #101) was outside smoking with another resident. Reported to (Name of daughter) I discussed with (Resident #101) that (Name of Facility) was a non-smoking facility. Will continue to assist as needed." Review of the clinical record failed to evidence documentation of any smoking assessment or that Resident #101 had been assessed as safe to smoke unsupervised.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 94 Resident #101 was not observed during the survey to be smoking. Review of the comprehensive care plan dated 6/4/19 and revised on 9/8/19,failed to evidence any documentation of smoking by Resident #101. An interview was conducted with ASM (administrative staff member) #2, the director of nursing on 11/14/19 at 9:44 a.m. When asked if the facility was a smoking or non-smoking facility, ASM #2 stated it was a non-smoking facility since before I got here in June 2018. When asked if the residents are assessed for safe smoking, ASM #2 stated, "We don't assess them because we are a non-smoking facility." When asked if the care plans should document the fact that the resident is smoking, ASM #2 stated, "Yes, it should." A copy of Resident #101's sign out sheet was requested on 11/14/19 at approximately 11:15 a.m. A copy of Resident #101's "Release of Responsibility for Leave of Absence" form failed to evidence the resident was signing out to go smoke. The only entries on this form from 6/7/19 through 11/7/19 were for doctor's appointments, out with family and hair appointments. The "Smoking - Safety Screen" was completed on 11/14/19 at 2:50 p.m. after the Immediate Jeopardy was called. An interview was conducted with Resident #101 on 11/14/19 at 4:00 p.m. When asked if she smokes, Resident #101 stated she never smoked at home. Resident #101 stated that her mind was "not right" she forgets things. When asked how	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 95 often she smokes, Resident #101 stated, "Only occasionally." When asked where she gets the cigarettes, Resident #101 stated someone gives them to her. When asked if it was a staff member, Resident # 101 stated, "No, it's a male resident who smokes too. He lights them for me too." When asked if her family brings her cigarettes, she stated no. An interview was conducted with OSM (other staff member) #3, the social services director, on 11/18/19 at 10:40 a.m. When asked about Resident #101's smoking, OSM #3 stated, "She was admitted in June, she hadn't been smoking at all that I was aware of. She had become friends with another male resident and that first day I found them outside smoking. On that day, I spoke to the resident and explained it was a non-smoking facility. She (Resident #101) stated that she had seen other residents smoking and I told her they weren't supposed to be, they were non-compliant. I explained that I had to call her daughter and she (Resident #101) didn't want me to do that. The daughter stated she would not be buying her any cigarettes. When asked if she notified anyone about Resident #101's smoking on the property, OSM #3 stated she told the daughter, (Resident #101) and the IDT (interdisciplinary team)." When asked if she notified the doctor or nurse practitioner, OSM #3 stated, "I may have notified (name of nurse practitioner) but not positive. I believe she was aware." ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the vice president of clinical services, were notified of the above concern during the Immediate Jeopardy on 11/14/19 at 1:56 p.m.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 689	Continued From page 96 No further information was provided prior to exit.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 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, facility document review and clinical record review, it was determined that the facility staff failed to ensure respiratory care consistent with professional standards of practices for one of 60 residents in the survey sample, Resident # 86. The facility staff failed to ensure a full E-cylinder of oxygen for Resident #60 was properly stored and secured. The findings include: Resident #86 was admitted to the facility on 10/15/19 with diagnoses that included but were not limited to: COPD [chronic obstructive pulmonary disease] (1), anxiety disorder, and GERD [gastroesphogeal refulx disease] (1). The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 10/21/19, coded the resident as scoring a "14" on the BIMS (brief	F 695	**F 695** It is the practice of this facility that oxygen tanks are stored safely & securely **I** Following room rounds, in which all oxygen tanks were found to be properly stored the morning of 11/12/19, delivery person from an outside hospice company delivered oxygen to the resident #86 and left the tank in the position in which it was found. She/he did not notify nursing management that the supply had been left in the room unattended. Residents#86 oxygen tank was secured immediately upon notice that it was not secured. on 11/12/19 The facility NHA contacted the hospice agency regarding the issue and educated the hospice staff to educate the delivery service of F 689, proper storage of oxygen tanks **II** The NHA and/or /DON conducted an immediate audit of oxygen tanks facility wide on 11/12/19 and no other oxygen tanks were found to be left standing without being in appropriate holders. **III** The facility NHA conducted education for the hospice company delivery person regarding:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 97 interview for mental status) score, indicating he was capable of making daily cognitive decisions. The resident was coded as requiring supervision to limited assistance for his activities of daily living. In Section O - Special Treatments, Procedures and Programs, the resident was coded as using oxygen while a resident at the facility. The physician orders dated, 10/15/19, documented, "Oxygen therapy at 4 liters per minute via nasal cannula every shift for COPD." The physician order dated, 10/17/19, documented, "Resident is under the care of (name of company) hospice." Observation was made of Resident #86's room upon initial screening on 11/12/189 at approximately 12:20 p.m. Resident #86 was in his recliner with his oxygen in use via an oxygen concentrator. Observed under the sink were five E cylinders of oxygen. Four of the oxygen tanks were secured in a cardboard rack. One full tank with the seal still in place, was sitting next to the cardboard rack, and not secured. A second observation was made of Resident #86's room on 11/12/19 at 1:36 p.m. and the oxygen tank was still under the sink, unsecured. At this time, ASM (administrative staff member) #1, the administrator, was walking into Resident #86's room. When shown the unsecured tank, ASM #1 stated, "Hospice did that." ASM #1 stated, "It needs to be removed immediately." ASM #1 proceeded to remove the unsecured oxygen tank out of the room. Observation of the oxygen storage rooms was conducted on both units. All oxygen tanks were secured.	F 695	• F 695 as it relates to safe storage of oxygen. The DON and/or ADON conducted in-service education for nursing staff on 11/20/2019 or before compliance date regarding: • F 695 as it relates to oxygen storage and security IV The Unit Managers, ADON or DON will complete an audit of residents with oxygen to ensure that oxygen cylinders are secured appropriately. This audit will be conducted daily, 5 days per week for 2 weeks, then weekly for 4 weeks, then monthly. Any discrepancy noted during the audit will be addressed at that time. The DON will submit results of the audit monthly to the QAPI committee for its review and recommendations. Date of compliance: 12/16/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 98 The facility policy, "Oxygen Safety" documented in part, "1. Oxygen cylinders must be stored in racks with chains, sturdy portable carts and/or approved stands." ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional vice president of clinical services, were made aware of the above concern on 11/15/19 at 2:00 p.m. No further information was provided prior to exit. References: (1) COPD- chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) GERD- gastroesphogeal refulx disease - backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the esophagus, commonly known as heartburn. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243.	F 695		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at	F 727	F 727 It is the practice of this facility to have RN coverage 7 days per week for 8 consecutive hours. I Past non-compliance with RN coverage of 8 consecutive hours per day cannot be corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 727	Continued From page 99 least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. 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 ensure RN (Registered Nurse) coverage for at least 8 hours a day, every day. A review of the staffing schedules and postings revealed several dates where there was no RN on duty. The findings include: A review of the as-worked schedule for 30 days and the staff postings revealed there was no RN coverage on the following dates: 10/12/19 10/13/19 10/20/19 10/21/19- [Review of the staff posting for 10/21/19, documented 24 hours of RN coverage. This was not reflected on the as-worked schedule. No evidence was provided, that an RN was on duty this date.] 10/24/29 - [Review of the staff posting for 10/24/19, documented 16 hours of RN coverage. This was not reflected on the as-worked schedule. No evidence was provided, that an RN	F 727	II The facility hired a new staffing coordinator on October 24, 2019, staffing coordinator will notify the Director of Nurses anytime there is an issue with the schedule regarding RN coverage. III The DON or ADON provided an educational review on 12/2/2019 for the staffing coordinator and the Unit Managers regarding: • the regulation F 727 and the requirement to have an RN for 8 consecutive hours daily. IV The NHA or DON will conduct an audit of the nursing staffing schedule to verify that there is RN coverage per the regulation, 8 consecutive hours, 7 days per week. This audit will take place 5 days per week for 2 weeks, then weekly X 4 then monthly X 2. Any discrepancy noted during the review will be addressed with an RN called to cover the schedule hole. The DON will submit results of the audit to the QAPI committee monthly for its review and recommendations. Date of Compliance: 12/16/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 727	Continued From page 100 was on duty this date.] 10/25/19 10//25/19 11/9/19 11/10/19 A review of the staff posting revealed that there was no RN scheduled for the following dates: 10/12/19 - this was in agreement with the as-worked schedule. 10/13/19 - this was in agreement with the as-worked schedule. 11/9/19 - this was in agreement with the as-worked schedule. On 11/15/19 at 9:29 AM, an interview was conducted with OSM #5 (Other Staff Member) the staffing coordinator. When asked about the requirements for RN coverage, OSM #5 stated that there has to be one RN daily. When asked if she had ensured there is one daily, OSM #5 stated, "We have 2 RN's on staff; we call the other one to come in when one calls out." When asked about the dates in question for missing RN coverage, OSM #5 stated that she had been in the position for 2 weeks and was getting assistance from RN #1 (the Assistant Director of Nursing) on how to do the schedule. OSM #5 stated that she did not start doing the schedule until about November 1, 2019. On 11/15/19 at 12:47 PM, an interview was conducted with OSM #18 the previous schedule coordinator, she stated that she was not doing the schedule as of October 11, 2019. On 11/15/19 at 12:47 PM, in an interview with OSM #19, who was the staffing coordinator from 9/30/19 to 10/14/19, she stated that, there has to	F 727		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 727	Continued From page 101 be a nurse (RN or LPN - Licensed Practical Nurse) on each hall. OSM #19 stated she was not told anything specific about the requirements for RN coverage. On 11/15/19 at 1:03 PM, an interview was conducted with ASM #2 (Administrative Staff Member, the Director of Nursing). ASM #2 stated that OSM #18 made the schedule through 11/7/19 and the facility continued to follow that schedule until its conclusion, even though it was after OSM #18 was no longer the staffing coordinator. On 11/15/19 at 1:13 PM, in a follow up interview with OSM #18, she stated that the facility only had 1 full time RN and two part-time RN's at the time she made the schedule. OSM #18 stated that there was not enough RN's on staff to cover it all because one of the part-time RN's only worked Sunday's and Monday's and the other worked every other weekend and picked up other times only if it did not interfere with her other job. OSM #18 stated that the requirements for RN coverage was there had to be one scheduled per day, any shift, for at least 8 hours. OSM #18 stated that the facility did not have the RN's available to meet that requirement. She stated that the DON (director of nursing)or ADON (assistant director of nursing) does not count. On 11/15/19 at 2:00 PM, ASM #1, the Administrator, was made aware of the findings. Policies were requested regarding staffing requirements. None were provided. No further information was provided by the end of the survey.	F 727		
F 732	Posted Nurse Staffing Information	F 732	F 732 It is the practice of this facility to post daily staffing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 732 SS=C	Continued From page 102 CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 732	I Past non-compliance with posting requirement cannot be corrected. II The staffing posting information will be readied and posted per the regulation. The staffing posting will be updated at the beginning of each shift to reflect the current census and changes to the staffing, if indicated by nursing management. III The DON or ADON or NHA conducted an in-service for the staffing coordinator on 12/02/2019 or before compliance date and licensed nurses regarding: • F 732 as it relates to posting and updating the staff posting with current information IV The DON or ADON or HR director will audit the posting of the daily staffing to ensure that the posting is up daily and that it is updated each shift with the number of staff and current census. This audit will take place daily, 5 days per week for 4 weeks, then weekly for 4 weeks. Any discrepancy noted in the audit will be corrected at that time. The HR director will submit results of the audit monthly to the QAPI committee for its review and recommendations. Date of compliance: 12/16/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 732	Continued From page 103 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review it was determined that the facility staff failed to ensure a continuous, accurate posting of the facility staffing. Observation of the staff posting upon entrance to the facility on 11/12/19 11:40 AM, revealed the staff posting for Friday, 11/8/19. There was no evidence of a current posting was observed. The findings include: On 11/15/19 at 9:45 AM RN #1 (Registered Nurse) the Assistant Director of Nursing was asked about who posts the staffing. She identified OSM #6 (Other Staff Member) who she stated was the person at the front desk, the secretary. On 11/15/19 at 9:54 AM, in an interview with OSM #6, she stated that her position was Accounts payable/Executive Assistant. When asked about the staff posting, OSM #6, stated that the master schedule is input into the computer and then pulls the data for the staffing hours. She stated that she then prints it and hangs it. When asked what knew about the requirements of posting the staffing, OSM #6 stated, "I know we are supposed to post it every day. It doesn't get done on the weekends. I post it on Friday morning and there is no one else who has access to the computer because to print it you have to get into the payroll system and they don't want everyone getting into the payroll system." OSM #6 was asked when the next one was posted. OSM #6 stated, Tuesday morning when I came back to work. When asked what time she came back to	F 732		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 732	Continued From page 104 work, OSM #6 stated, "At 7:30 AM when I came in on Tuesday morning. When asked about the observation upon entrance at 11:30 AM on Tuesday, 11/12/19, of the wrong posting, left in place since Friday, 11/8/19, OSM #6 stated, "I was on vacation and when they called and said you (the state agency) were here I told them they had to print it and post it." When asked whom else had the capability to post it if she was not in the facility, OSM #6 stated, "HR posted it. She is here 9-5 Monday to Friday." Regarding to her comment that she posts the staffing first thing in the morning (after the start of day shift), OSM #6 was asked, if there are any changes to the census, or staffing related to call-outs, etc., on evening and night shifts, is the posting updated before each shift to accurately reflect the changes. OSM #6 stated, "It is done once a day in the morning and is not updated/adjusted for census changes through the day or if there are call outs for an upcoming shift. It may not be accurate with schedule changes if they cannot find someone to replace the staff member that called out." A review of 30 days of staff posting failed to reveal evidence of cross-outs and changes in census and staffing, as they occur. All 30 days were clean copies as originally printed without noted changes, corrections, or adjustments; and it was noted that at least for RN coverage, the posting was not accurate on 10/21/19 and 10/24/19, as these dates reflected RN coverage (24 hours and 16 hours respectively) when the as-worked schedules revealed there were none. On 11/15/19 at 2:00 PM, ASM #1, the Administrator, was made aware of the findings.	F 732		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 732	Continued From page 105 Policies were requested regarding staffing requirements. None were provided. No further information was provided by the end of the survey.	F 732		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to prepare and serve food in a sanitary manner. The findings include: On 11/13/19 from 11:42 AM to 12:40 PM, an observation was made of the tray line service. The following issues were observed:	F 812	F 812 I Past non-compliance cannot be corrected II The dietary staff will prepare and serve food items under sanitary conditions The facility NHA had the butcher block wood piece on the steam table covered with a non-porous material on 12/5/2019 Foods will be transported with appropriate covers. The dietary staff will wash hands after touching items which are contaminated Dietary staff will maintain good infection control practices when handling plates, cups, glasses and silverware. III The facility NHA conducted education for the dietary staff on 12/12/2019 or before compliance date regarding: • F 812 regulation as it pertains to kitchen sanitation • Handwashing • Covering food items during transport • Not using items in the kitchen that cannot be sanitized.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 812	Continued From page 106 1. OSM #10 (Other Staff Member, dietary staff) was preparing the plates for each tray. The tray line contained a wooden butcher-block surface area for setting items on. The wooden surface was noted to contain stains of various age appearance. She had the same pair of gloves on throughout the tray line service. She was noted to touch this stained wooden surface multiple times with her gloved hands. She was noted to place the tongs used to pick up fish and Salisbury steaks, directly on the wooden surface. OSM #10 was noted to handle plates, bowls, serving tongs and spoons, and touch various surfaces of the steam table / tray line equipment with the same gloves on that touched the stained butcher-block surface. She was observed to handling each plate as she prepared it with her thumbs on the rim of the plates. OSM #10 was observed using her fingers to reposition food items that landed on the plate in a disorganized fashion. She was noted picking up bowls with her fingers down inside the food -contact surface area of the bowls. As she prepared each plate, she was observed picking up a sprig of parsley with her fingers and putting it on each plate. She was observed obtaining stacks of plates from the plate warmer, holding them against her shirt as she transported them from the warmer to the steam table. On 11/15/19 at 10:53 AM, in an interview with OSM #15, the dietary manager, when asked about the butcher-block surface, she stated that it is a porous surface. When asked how it is cleaned, OSM #15 stated a "regular all-purpose cleaner." When asked if this ensured the butcher-block surface was sanitized through and through, OSM #15 stated that she cannot ensure	F 812	IV The facility NHA or RD or will conduct rounds in the kitchen to verify that infection control measures are followed. This audit will take place 5 days per week for 2 weeks, then weekly for 4 weeks, then randomly. Any discrepancy noted during the audit will be addressed with additional education to the dietary staff member(s). Results of the audit will be submitted to the QAPI committee for its review and recommendations. Date of Compliance: 12/16/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 812	Continued From page 107 that. When asked about the observations of thumbs on the plates, OSM #15 stated that thumbs should not be on the top of the plate. When asked about carrying plates against one's shirt, OSM #15 stated that the plates should not be in contact with clothes that way. When asked about the observation of fingers down in the bowls, OSM #15 stated that fingers should not be down in the bowls. When asked about using fingers to position food on the plate, OSM #15 stated that fingers should not be used to scoop food back together. She stated there is no reason to be touching the top of the plate at all. When asked about the parsley, OSM #15 stated that it should have been picked up with tongs. When asked about the serving tongs for the fish and Salisbury steak laying on the stained butcher-block surface, OSM #15 stated that the serving end should not be on the butcher block. 2. OSM #11, dietary staff, was preparing the trays. She had the same gloves on throughout. She was observed handling plate bases, dome covers, condiment packets, silverware, and the trays themselves. The trays were noted stacked and each one was noted to have the meal ticket, napkin, salt/pepper/sugar packets already. The bottom of the previous tray rested on these items on the next tray. As she picked up each tray from the stack and placed it on the tray line for preparation, OSM # 11 placed her hand on the napkin of each one, then obtained silverware and placed them on the napkin, which had already been in contact with her gloved hand and the bottom of another tray. She was also noted to touch some of the silverware on the food contact surface end with the same gloves on that touched other items.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 812	Continued From page 108 On 11/15/19 at 11:06 AM, in an interview with OSM #15, she stated that as long as she (OSM #11) did not move from the tray line and touch anything else, it was ok that she touched the napkins with her hand on the middle of it. But she should not touch the silverware on the eating end. 3. OSM #12, dietary staff, was at the end of the tray line. She did not have gloves on. Between each tray, her hands were noted to be at her side, touching her clothes. She was noted to placing beverage cups of tea on the trays. Each cup contained a plastic lid that covered the opening and the top of the rim of the cup. The lid did not cover any surface of the side of the rim of the cup where lips may meet during drinking from the cup. She was noted to pick each cup up at the top of the cup near the rim, with her bare hands, which had been resting at her sides between trays, touching her clothes. On 11/15/19 at 11:06 AM, in an interview with OSM #15, she stated that this was not sanitary. 4. OSM #13, dietary staff, was at the end of the tray line across from OSM #12. She wore the same gloves throughout tray line service. Between trays, she was noted to rest her hands on the upper level of the tray line equipment, on the rollers that the trays were moved along on like an assembly line. She was noted to finish the trays with the dome covers. Next to her was large metal bowls of ice containing cartons of milk. She was observed moving the ice around with her hands, and obtaining cartons of milk for the trays. With these same gloves, she was noted to add the dessert bowl to the tray, with her	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 812	Continued From page 109 thumb on the surface of the rim of the bowl. The bowls were not individually covered with any lid or plastic wrap. Her thumb was directly on the surface of the rim of each bowl. In addition, she was also noted to handle beverage cups of tea in the same manner as OSM #12 had. On 11/15/19 at 11:06 AM, in an interview with OSM #15, she stated that OSM #13 should not have her hands on the rollers and should not grab the cups at the top. OSM #15 stated, "I don't know how she could grab the dessert bowls any other way." 5. OSM #14, dietary staff, was in and out of the kitchen with a waist-high serving cart for the dining room. She was observed obtaining the plates, cups, dessert bowls, and saucers of rolls, from the dietary staff, for each resident in the dining room, and placing some on the top of the cart and some inside the cart. The cart did not have any doors on it to protect the food items inside it, or a lid / cover of some kind to protect the food items on top of it. OSM #14 then pushed this cart out into the main hallway and into the dining room across the hall to serve to the residents. For each resident, the saucers of rolls and bowls of dessert were not covered, and exposed as the cart was being pushed out of the kitchen into the hallway and dining room. On 11/15/19 at 11:06 AM, in an interview with OSM #15, she stated that food should be covered before leaving the kitchen. 6. OSM #15, the dietary manager, was observed obtaining an empty pitcher to be refilled, from a	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 812	Continued From page 110 staff member that came to the door of the kitchen. OSM #15 had at that moment, paper in one hand that she was going to throw away. She was noted to retrieve the pitcher from the staff member, went over to the trashcan, removed the lid and opened it with her other hand and diposed of the paper. OSM #15 then removed the lid from the pitcher to refill the pitcher, with the same hand she used to open the trash can lid. She did not wash her hands after handling the trash can and before handling the pitcher she refilled. On 11/15/19 at 11:06 AM, in an interview with OSM #15, she stated that she did not wash hands after touching the trash can lid and the tea pitcher lid but should not have handled anything after touching the trash can lid before washing her hands. A review of the facility policy, "Food Preparation: Dietary Food Handling" documented, "3. Food should be prepared and served with clean tongs, scoops, forks, spoons, spatulas or other suitable implements so as to avoid manual contact of prepared foods with hands....5. Prepared food should be transported to other areas in closed food carts or covered containers....15.b. Cutting boards should be of hard rubber construction rather than wood and must be dishwasher safe...." On 11/15/19 at 2:00 PM, ASM #1, the Administrator, was made aware of the findings. Policies. No further information was provided by the end of the survey.	F 812		
F 842	Resident Records - Identifiable Information	F 842	**F 842** It is the practice of this facility, in accordance with accepted professional standards and practices, to maintain a medical record which are complete, accurately documented, readily accessible and systematically organized.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 842 SS=D	Continued From page 111 CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert	F 842	I It was discussed with Resident #48 regarding the use of a smoking patch and #48 does not wish to have a smoking patch. II Residents who smoke can be offered a smoking patch. Smoking cessation will be discussed with each current resident, and new residents, that smoke. Care plans will be updated to reflect residents' preferences. III The facility smoking policy has been revised to include discussion with the resident regarding smoking cessation. IV The facility NHA and/or social services staff will conduct an audit of documentation of discussions with residents who smoke to verify smoking cessation has been discussed. This audit will be conducted monthly X 3. Any discrepancy noted in the audit will be corrected at that time. The Social Services director will submit results of the audit to the QAPI committee monthly for its review and recommendations. **Date of compliance: 12/16/2016**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 842	Continued From page 112 a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. 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 medical record for one of 59 residents, Resident #48. The physician's progress notes failed to document discussion regarding alternative to smoking. The findings include:	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 842	Continued From page 113 Resident #48 was admitted to the facility on 3/30/18 with diagnoses that included but were not limited to: Alzheimer's (progressive loss of mental ability and function often accompanied by personality changes and emotional instability (1), schizophrenia (mental disorder characterized by gross distortions of reality, withdrawal from social contacts, and disturbances of thought, language and perception) (2) and depressive disorder (dejected state of mind with feelings of sadness, discouragement, and hopelessness) (3). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 9/23/19, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. The resident was coded as independent for bed mobility, transfer, walking in room and corridor, locomotion on and off the unit, dressing, eating, toilet use and personal hygiene. The annual MDS with ARD of 3/23/19, coded the Resident #48's current tobacco use, as yes. The social service's note dated 2/12/19 at 1:40 PM, documented, "IDT (inter disciplinary team) members met to review resident's behaviors of this past week. (Resident #48) smokes, she is aware this is a non-smoking facility and is not to be smoking without a family member or friend accompanying her. She is also aware her family does not want her smoking. Team will continue to monitor." The care plan dated 2/6/19, documented in part, Focus: "Smoking: Non-compliant with smoking policy." The Goal: dated 2/6/19, documented, "(Resident #48) will not smoke against facility	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 842	Continued From page 114 policy through next review." The Interventions: dated 2/6/19, documented, "Remind her that she cannot smoke under the breezeway close to front doors and remind her that she may only smoke within the designated area on the front SW (south wing) patio and with family." The physician's progress note dated 9/2/19 at 11:44 AM, documented, "Smokes occasionally and considers herself smoke free. I have asked her to cut down or stop. She will consider." An interview was conducted on 11/18/19 at 2:30 PM with ASM (administrative staff member) #5, the resident's physician. When asked when he was notified Resident #48 smoked, ASM #5 stated, "I wasn't aware that she smoked till recently, I believe a couple of months ago." When asked if his note of 9/2/19 which documented smoking was his first awareness, ASM #5 stated, "Yes it was." When asked if he had discussed alternatives to smoking with Resident #48, ASM #5 stated, "I considered a patch and discussed with her. Resident #48 feels she smokes so little, that she is smoke free. I was afraid to prescribe it, since I worry that she will wear the patch and smoke also." When asked where this was documented in the medical record, ASM #5 stated, "If it's not in that note, then I didn't document it. I didn't order the patch." When asked if it should be documented, ASM #5 stated, "Yes, I thought I had documented it there in the note." ASM #1, the administrator, ASM #2, the DON (director of nursing) and ASM #3, the regional VP (vice president) for clinical services were informed of the incomplete medical record for Resident #48 on 11/18/19 at 3:50 PM.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 842	Continued From page 115 No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 25. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 518. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 157.	F 842		
F 947 SS=F	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §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, facility document	F 947	F 947 It is the practice of this facility to provide at least 12 hours of in-service training annually for nursing aides. I There was no specific resident identified in the 2567. Past non-compliance cannot be corrected for the employees identified in the 2567. II A review of the training materials revealed that the ADON was counting training done in a calendar year as opposed to hire date. Some of the subject material that was completed was discounted by the surveyor reviewing the material as not counting towards the 12 hours A new tracking form for annual training has been developed and the facility will track in-services using this form as well as by employment year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 116 review, and employee record review, it was determined that the facility staff failed to meet the training requirements for eight of 15 CNA (Certified Nursing Assistant) employee records reviewed, (CNA #4, CNA #5, CNA #6, CNA #7, CNA #8, CNA #9, CNA #2 and CNA #100. The findings include: A review of education records was conducted for 15 facility CNA records. The following was identified: 1. CNA #4 did not complete the required 12 hours of training during her anniversary year of 2/3/18 to 2/3/19. She completed 7.75 hours. 2. CNA #5 did not complete the required 12 hours of training during her anniversary year of 6/27/18 to 6/27/19. She completed 10 hours. 3. CNA #6 did not complete the required 12 hours of training; did not complete dementia care training during her anniversary year from 11/7/18 to 11/7/19. She completed 4.25 hours. 4. CNA #7 did not complete the required 12 hours of training; did not complete dementia care training during her anniversary year from 2/16/18 to 2/16/19. She completed 3.5 hours. 5. CNA #8 did not complete the required training's of abuse prevention and dementia care during her anniversary year of 5/19/18 to 5/19/19. 6. CNA #9 did not complete the required 12 hours of training and did not complete abuse prevention training during her anniversary year of 3/4/18 to 3/4/19. She completed 7.25 hours. 7. CNA #2 did not complete the required 12 hours of training; did not complete dementia care training during her anniversary year of 10/3/18 to 10/3/19. She completed 9.5 hours.	F 947	III The NHA conducted a review for the DON and ADON on 11/19/2019 regarding: • F 947 and educational requirements for aides, • the new tracking form and • need for training to be 12 hours every year, from the hire date. The ADON conducted in-service training for nurse aides in dementia training as well as abuse prevention, recognition and reporting on 12/10/2019 or before compliance date. IV The DON or NHA will conduct a monthly review of in-service training on facility nurse aides to ensure that each is attending in-service education to reach at least 12 hours per employment year. Any discrepancy noted in the audit will be addressed with the employee to ensure attendance at education/ in-services. The ADON /staff educator will submit results of the audit monthly to the QAPI committee for its review and recommendations. Date of compliance: 12/16/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 117 8. CNA #10 did not complete the required 12 hours of training and did not complete the abuse prevention or dementia care training's during her anniversary year of 2/6/18 to 2/6/19. She completed zero hours. On 11/15/19 at 12:19 PM in an interview with RN #1 (Registered Nurse), the Assistant Director of Nursing, she stated that she did not know why the hours and required abuse and dementia training's were not completed. RN #1 stated that she tracks them now but during some of the times frames she was not doing the education. RN #1 stated that she did not know who was doing it before. She stated that she had been doing it since March 2019. RN #1 stated that upon hiring, in their packet is a paper that lists their required in-services, and that the company puts out a 12-month calendar that the facility follows and she hangs one at the time clock. RN #1 stated there were no policies regarding the training requirements. A review of the page from the hiring packet documented the following: "...All employees must participate in mandatory inservices. Other mandatory inservices may be added that are not included in the list below: LIST OF REQUIRED INSERVICES: Customer Services Basics, Resident Rights, The Aging Process, Adding To Business Results, Ethics, Preventing The Spread of Infection, Tuberculosis, Bloodborne (Sic.) Pathogens, Accident Prevention, Heimlich Maneuver, Chemical Safety, Fire Prevention and Response, CPR [cardiopulmonary resuscitation] (Mandatory for RN's and LPN's [licensed practical nurse] only)."	F 947		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 118 A review of the annual calendar documented as "2018-2019 In-services" documented as follows (Training's that was identified as being required for all staff or for CNA's listed below for the purpose of this citation): January: Seasonal Flu, COPD (Chronic Obstructive Pulmonary Disease), Maintaining good communication. February: Sexual Harassment, Hydration Needs, Diabetes Basics, Calculating Meal Percentages. March: Breaking the Chain of Infection, The importance of good nutrition, Basic C-Diff (clostridium difficile) April: Understanding the Aging Process, Ergonomics, Understanding Dementia. May: Vulnerable Adult Protection, Understanding Stroke. June: Environmental Safety, Fire Safety, Safety Data Sheets, Healthcare worker Abuse, Work place violence, Active Shooter. July: Wandering/Elopement, Heimlich Maneuver, Fall Restraint Reduction, Body Positioning/Preventing foot drop, contractures, and pressures. August: Qapi (quality assurance and performance improvement), Role as Nursing assistant. September: HIPAA/HITECH (Health Insurance Portability and Accountability Act / Health Information Technology for Economic and Clinical	F 947		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 11/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 119 Health), Pressure Ulcer Prevention. October: Caring for Alzheimer's client, Back Safety, Dining Experience. November: Isolation Precautions. December: Resident Adjustment to transfer, Incontinence 101, Lift use review. On 11/15/19 at 2:00 PM, ASM #1, the Administrator, was made aware of the findings. Policies were requested regarding staffing requirements. None were provided. No further information was provided by the end of the survey.	F 947		