SKYLINE TERRACE NURSING HOME

P.O. Box 558 Woodstock, Virginia 22664

October 22, 2018

Telephone: (540) 459-3738

Wietske Weigel-Delano Department of Health 9960 Mayland Drive, Suite 401 Henrico,VA 23233-1485

Dear Ms. Delano,

Attached you will find the Skyline Terrace Nursing Home's Plan of Correction for Licensure survey ending on 10/4/2018. If you have any questions, please do not hesitate to contact me.

Sincerely,

Administrator

OCT 24 2018 VDH/OLC

Fax: (540) 459-8651

PRINTED: 10/11/2018 **FORM APPROVED** OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		49E075	B. WING			10	/04/2018
	PROVIDER OR SUPPLIER TERRACE CONV HO	OME		P	TREET ADDRESS, CITY, STATE, ZIP CODE O BOX 558 VOODSTOCK, VA 22664	10,	77.010
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E 000	Initial Comments		Ε¢	000	0.		
F 000	survey was conduc The facility was in s CFR Part 483.73, F	•	F	000			
	survey was conduc Corrections are req						
F 550 SS=D	at the time of the su consisted of 23 cur (Residents #20, #6 #67, #40, #58, #36, #24, #25, #5, #8, # record review (Resi	ercise of Rights	F.5	550			
	self-determination, access to persons a	nt Rights. right to a dignified existence, and communication with and and services inside and including those specified in			RECEIVED		
	with respect and dig resident in a manne promotes maintena her quality of life, re	ility must treat each resident gnity and care for each er and in an environment that nce or enhancement of his or ecognizing each resident's			OCT 2 4 2018 VDH/OLC		,
AROBATORY	DIDECTOR'S OR BROVID	ED/SLIDDLIND DEBOESENTATIVE'S SIGN	IATUDE		' TITLE		2401 5 175

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

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AND PLA	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		49E075	B. WING _		10/04/2018
SKYLI	F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 558 WOODSTOCK, VA 22664	1010-1/2010
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F 55	individuality. The far promote the rights of \$483.10(a)(2) The faccess to quality caseverity of condition must establish and practices regarding provision of services residents regardless. §483.10(b) Exercise The resident has the rights as a resident or resident of the United Services (sinterference, coercider to the facility. §483.10(b)(1) The facility. §483.10(b)(2) The refree of interference, reprisal from the facility. §483.10(b)(2) The refree of interference, reprisal from the facility. This REQUIREMEN by: Based on observation document review and was determined that a resident's dignity for survey sample, Resident # 53's cath	cility must protect and of the resident. acility must provide equal are regardless of diagnosis, a, or payment source. A facility maintain identical policies and transfer, discharge, and the sounder the State plan for all sof payment source. To of Rights. To right to exercise his or her of the facility and as a citizen nited States. Acility must ensure that the se his or her rights without on, discrimination, or reprisal desident has the right to be coercion, discrimination, and allity in exercising his or her ported by the facility in the er rights as required under this are rights as required under this are not met as evidenced on, staff interview, facility diclinical record review, it facility staff failed to maintain or one of 24 residents in the dent # 53. In the provide privacy for eter collection bag.	F 55	1. How will corrective action be accomplished for those residents found to be affected by the deficient practice? A privacy bag is being utilized on Resident #53's catheter bag. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? DON and/or designee will audit residents with indwelling catheter collection bags to ensure that privacy bags are being used appropriately.	10/4/2018
ORM CMS-2	567(02-99) Previous Versions C	Obsolete Event ID: R9RL11	Fa	acility ID: VA0226 OCT 2 4 2018 If continua	tion sheet Page 2 of 62
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FORM CMS-2567(02-99) Previous Versions Obsotete



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		49E075	B. WING		10	/04/2018
	PROVIDER OR SUPPLIER TERRACE CONV HO	DME	P	TREET ADDRESS, CITY, STATE, ZIP CODE O BOX 558 OODSTOCK, VA 22664		
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F 550	11/07/17 with diagn not limited to: benig gout (2), hemiplegial Resident # 53's moset), an annual ass (assessment reference Resident # 53 as so interview for mentary - 15, 7 (seven) - be cognition for making 53 was coded as retotal assistance of cofficial diving. Sect coded Resident # 5 catheter. On 10/02/18 at approbservation was conceived Resident 53's catheter soom, lying in be collection bag was as of bed, on the entral catheter bag was head. Resident # 53's be seen from hallway. On 10/03/18 at approbservation was conceived the room, lying in be collection bag was conceived the room, lying in be collection bag was conceived to the entral sample of bed, on the entral sample of the sample of bed, on the entral sample of the sa	admitted to the facility on oses that included but were in prostatic hyperplasia (1), a (3) and hypertension (4). In trecent MDS (minimum data essment with an ARD ence date) of 09/09/18, coded coring a 7 (seven) on the brief is status (BIMS) of a score of 0 ing severely impaired of g daily decisions. Resident # equiring extensive to requiring one staff member for activities in H "Bladder and Bowel" 3 as having an indwelling roximately 1:18 p.m., an inducted of Resident # 53 and other collection bag. Resident # e bed, next to the entrance of ed. Resident #53's catheter observed hanging off the side ince side of the room. The anging outside of the privacy is catheter collection bag could	F 550	3. What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur? DON and/or designee will provide education to nursing staff to ensure that catheter collection bags are stored appropriately inside privacy bag.		10/25/2018

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING		3) DATE SURVEY COMPLETED		
		49E075	B. WING		10/	04/2018
	PROVIDER OR SUPPLIER ETERRACE CONV HO	DME		STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 558 WOODSTOCK, VA 22664		
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F 550	bag. Resident # 53' be seen from hallwade seen from hallwade severely impaired of could not be intervied observations of the being placed in a prodignity. The comprehensive with a revision date Focus: (Resident # 50 has catheter. 16 FR (Froballoon r/t (related to "Interventions it door (Resident # 53) has catheter. Position of the level of the blade entrance room door indicated." On 10/03/18 03:20 conducted with CN/1 who had just com When asked about catheter collection bis always in a cover the floor and position from the hallway." Observe Resident # asked what she couthe collection bag a further stated, "It ne interview at approxiticensed practical residual practical residual residua	s catheter collection bag could ay. coding of Resident # 53 being for cognition, Resident 53's	F 550	4. How does the facility plan to monitor it's performance to make sure that the solutions are sustained? DON and/or Designee will monitor catheter privacy bags to ensure catheter collection bags are stored appropriately inside privacy bags weekly x3 weeks. DON will report results to the QA committee. Findings and results will be reflected in the QA minutes.	11/16/2	11/16/2018

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Event ID: R9RL11

Facility ID: VA0226

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		49E075	B. WING		10	/04/2018		
,	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C PO BOX 558 WOODSTOCK, VA 22664		704/2010		
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F 550	conducted with LP 2. When asked with collection bag and stated, 'In front of it she entered Resid LPN # 2 stated, "I in the privacy bag was out of sight." placement of a rest LPN # 2 stated, "The facility's policy "Catheter bedside in a privacy bag for the facility's "Resident has respect and dignity and receive service reasonable accommand preferences eventually and receive serv	p.m., an interview was N (licensed practical nurse) # here Resident # 53's catheter tubing was located, LPN # 2 the door." When asked why ent # 53's room at 3:24 p.m., saw the catheter bag was not completely and I replaced so it When asked about the sident's catheter collection bag, he bag should in a privacy so it "Catheter Care" documented, drainage bag should be placed r Resident's dignity." dent's Rights" documented, the right to be treated with y, including: The right to reside es in the facility with modation of resident needs except when to do so would the or safety of the resident or proximately 5:00 p.m., ASM ff member) # 1, the ASM # 2, director of nursing of the findings. tion was provided prior to exit.	F 5.	50				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49E075	B. WING		10/	04/2018
	PROVIDER OR SUPPLIER	DME	F	PO BOX 558 NOODSTOCK, VA 22664		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 550	Continued From pa	ge 5	F 550	A) PPO		2 1 2 2
	(2) A type of arthritis builds up in blood a joints This informat website: https://medlineplus. (3) Also called: Hen Quadriplegia. Para function in part of your something goes were pass between your can be complete or both sides of your bone area, or it can be	s. It occurs when uric acid nd causes inflammation in the tion was obtained from the gov/ency/article/000422.htm. niplegia, Palsy, Paraplegia, lysis is the loss of muscle our body. It happens when ong with the way messages brain and muscles. Paralysis partial. It can occur on one or ody. It can also occur in just be widespread. This ained from the website:		1. How will corrective action be accomplished for those residents found to be affected by the deficient practice? Resident #15's call bell was placed within reach.	10/3/	2018
	obtained from the whttps://www.nlm.nihessure.html. Reasonable Accommed CFR(s): 483.10(e)(3) §483.10(e)(3) The reservices in the facilia accommodation of a preferences except endanger the health other residents. This REQUIREMENT by: Based on observation document review are was determined that provide accommodation of a preferences except endanger the health other residents.	.gov/medlineplus/highbloodpr modations Needs/Preferences 3) ight to reside and receive ty with reasonable	F 558	2. How will the facility identify other residents having the potential to be affected by the same deficient practice? DON and/or Designee will conduct a facility audit to ensure call bells are within each Resident's reach.	10/	04/2018

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION NG	[` 'co	
		49E075	B. WING _		10/	04/2018
	PROVIDER OR SUPPLIER E TERRACE CONV HO	OME		PO BOX 558 WOODSTOCK, VA 22664		
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F 558	call bell (a device we pushed to alert staft was within the resident was within the resident was within the resident # 15 was 09/22/17 with diagrant limited to: aphainfarction (3) and he resident # 15's moset), an annual assessment references (assessment references for mentarity for mentarity for mentarity for mentarity for mentarity for making daily decoded as totally de	ed to ensure Resident #15's vith a button that can be f when assistance is needed), dent's reach. e: admitted to the facility on loses that included but were sia (1), dysphagia (2), cerebral	F 55	3. What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur? DON and/or designee will provide staff education to ensure that call bells are accessible to residents. 4. How does the facility plan to monitor it's performance to make sure that the solutions are sustained? DON and/or Designee will monitor resident call bell placement weekly x3 weeks to ensure continued compliance. DON will report results to		11/16/2018
	to locate it. On 10/03/18 at 2:04 his room reclined in his bed. Observation	1 p.m., Resident # 15 was in a Gerri chair sitting next to on of Resident # 15's bed Il was lying in the middle of		the QA committee. Findings and results will be reflected in the QA minutes.		11/16/2018

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		49E075	B. WING		10	/04/2018	
	PROVIDER OR SUPPLIER E TERRACE CONV HO	DME		STREET ADDRESS, CITY, STATE, ZIP COD PO BOX 558 WOODSTOCK, VA 22664			
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F 558		ge 7 sident # 15 was asked to ate the call bell, he was unable	F 558			<u>;</u>	
	The comprehensive dated 09/22/2017 d (Resident # 15) has living) self-care per right sided hemipar contracture of right it documented, "End	e care plan for Resident # 15 ocumented, "Focus. s an ADL (activities of daily formance deficit r/t (related to) esis age, immobility and hand." Under "Interventions" courage the resident to use tance. Date initiated:					
	conducted with CNA 2 and # 3. When a resident's call bell, (should be within res # 3 were then asked and the placement acknowledged Resi next to his bed and of Resident # 15's to reach of Resident # brought Resident #	p.m., an interview was A (certified nursing assistant) # sked about the placement of a CNAs # 2 and # 3 stated, "It sident's reach." CNAs # 2 and d to observe Resident # 15 of his call bell. They ident # 15 was in a Gerri chair the call bell was in the middle bed and that it was not within 15. When asked if they had 15 back to his room from as # 2 and # 3 stated no.				32. ²	
	conducted with CNA placement of a residence of a re	7 p.m., an interview was A # 4. When asked about the dent's call bell, CNA #4 stated, bell is within his reach." After ion of Resident # 15's call bell I if Resident # 15 could reach 4 stated, "No." When asked dent # 15 back into his room A # 4 stated, "When I brought at him next to the bed and over on the bed and put his					

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Facility ID: VA0226

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		49E075	B. WING			10/	04/2018
	PROVIDER OR SUPPLIER	OME		STREET ADDRESS, CITY, STATE, Z PO BOX 558 WOODSTOCK, VA 22664	IP CODE	1 105	04/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		TION SHOULD THE APPROPI	BE	(X5) COMPLETION DATE
F 558	no idea how it was Resident # 15 had to the middle of the 4 stated, "No." The facility's policy documented, "Call residents when the bathroom." The facility's "Resident has the respect and dignity and receive service reasonable accommand preferences expendents." On 10/03/18 at application (administrative staff administrator and Awere made aware of the brain that contributed for you to reasonable: (1) A disorder cause the brain that contributed for you to reasonable: (1) A disorder cause the brain that contributed for you to reasonable: (2) A disorder cause the brain that contributed for you to reasonable: (3) A disorder cause the brain that contributed for you to reasonable: (4) A disorder cause the brain that contributed for you to reasonable: (5) A disorder cause the brain that contributed for you to reasonable: (6) A disorder cause the brain that contributed for you to reasonable accomment to say) This if the website: (6) A disorder cause the brain that contributed for you to reasonable accomment to say) This if the website: (7) A disorder cause the brain that contributed for you to reasonable accomment to say) This if the website: (8) A disorder cause the brain that contributed for you to reasonable accomment to say) This if the website:	sure he could reach it. I have moved." When asked if the ability to move the call bell bed from his position, CNA # "Call Bell Utilization" bells should be accessible to y are in the room and / or dent's Rights" documented, he right to be treated with, including: The right to reside es in the facility with modation of resident needs accept when to do so would he or safety of the resident or proximately 5:00 p.m., ASM f member) # 1, the as M # 2, director of nursing of the findings. ion was provided prior to exit. ed by damage to the parts of oll language. It can make it d, write, and say what you information was obtained from in.gov/medlineplus/aphasia.htm	F 5	558			
	obtained from the v	sorder. This information was vebsite: n.gov/medlineplus/swallowingdi					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				SURVEY PLETED
		49E075	B. WING			10/0	04/2018
	PROVIDER OR SUPPLIER ETERRACE CONV HO	DME		P	TREET ADDRESS, CITY, STATE, ZIP CODE O BOX 558 VOODSTOCK, VA 22664		
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	brain stops. A strok attack." If blood flofew seconds, the boxygen. Brain cells damage. This infor website: https://medlineplus (4) High blood presobtained from the whittps://www.nlm.nifessure.html. Transfer and Disch CFR(s): 483.15(c) Transfer second from the whittps://www.nlm.nifessure.html. Transfer and Disch CFR(s): 483.15(c) (1) Facility must remain in the facility discharge the reside (A) The transfer or resident's welfare a cannot be met in the (B) The transfer or because the reside sufficiently so the reservices provided by (C) The safety of in endangered due to status of the resider (D) The health of ir otherwise be endar (E) The resident heappropriate notice,	a blood flow to a part of the e is sometimes called a "brain w is cut off for longer than a rain cannot get nutrients and can die, causing lasting mation was obtained from the gov/ency/article/000726.htm. sure. This information was vebsite: a.gov/medlineplus/highbloodpr arge Requirements 1)(i)(ii)(2)(i)-(iii) r and discharge- ity requirements- permit each resident to y, and not transfer or ent from the facility unless- discharge is necessary for the and the resident's needs be facility; discharge is appropriate nt's health has improved esident no longer needs the by the facility; dividuals in the facility is the clinical or behavioral nt; adviduals in the facility would		558	F622 1. How will corrective action be accomplished for those residents found to be affected by the deficient practice? The following items will be forwarded to Shenandoah Memorial Medical Records department for Residents #20, #24, #5, #40, and #64: A. Contact information of the practitioner responsible for the care of the Resident. B. Resident representative information including contact information.	11/16	5/2018

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Event ID: R9RL11

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DEPA	RTMENT OF HEALTH	AND HUMAN SERVICES			PRINTED:	10/11/2018
OTALEME	NT OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	OMB NO. ((X3) DATE	
NAME OF	PROVIDER OR SUPPLIER	49E075	B. WING		10/0	4/2018
	E TERRACE CONV HO	ME		STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 558 WOODSTOCK, VA 22664		
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	Nonpayment applies submit the necessar payment or after the Medicare or Medicai resident refuses to president who becomadmission to a facilit resident only allowabor (F) The facility cease (ii) The facility may not resident while the ap § 431.230 of this charge notice from 431.220(a)(3) of this discharge or transfer or safety of the resident when the facility may that failure to transfer when the facility transfer facility. The facility may of in paragraphs (c)(1)(i) section, the facility may or discharge is documedical record and apcommunicated to the institution or provider. (i) Documentation in the must include: (A) The basis for the total control of this section. (B) In the case of paragraphs, the specific resident, the specific resident under any of the specific resident, the specific resident under any of the specific r	s if the resident does not by paperwork for third party third party, including d, denies the claim and the ay for his or her stay. For a see eligible for Medicaid after by, the facility may charge a ble charges under Medicaid; as to operate. The peal is pending, pursuant to peal is pending, pursuant to per, when a resident ight to appeal a transfer or in the facility pursuant to \$ chapter, unless the failure to would endanger the health ent or other individuals in the fact document the danger or discharge would pose. The circumstances specified the circumstances specified the circumstances specified the circumstances specified the circumstances in the resident's peropriate information is receiving health care	F6	C. Advance Directive information. D. Special instructions or precautions for ongoing care. E. Care Plan Goals. F. All other necessary information including a discharge summary. Information forwarded to the Hospital will be documented in the Resident's facility medical record.	11/16/201	.8

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/11/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		49E075	B. WING	;		10/	04/2018
	ROVIDER OR SUPPLIER	DME		P	TREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 558 VOODSTOCK, VA 22664		
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F 622	(2)(i) of this section (A) The resident's p discharge is necess (A) or (B) of this sec (B) A physician whe necessary under pa this section. (iii) Information provimust include a mini (A) Contact informat responsible for the c (B) Resident repress contact information (C) Advance Directi (D) All special instruongoing care, as ap (E) Comprehensive (F) All other necess copy of the resident consistent with §483 any other document a safe and effective This REQUIREMEN by: Based on staff inte and facility docume that the facility staff required documentar receiving facility for sample; Residents 1. The facility staff required documentar	need(s). ion required by paragraph (c) must be made by- hysician when transfer or eary under paragraph (c) (1) ction; and in transfer or discharge is aragraph (c)(1)(i)(C) or (D) of vided to the receiving provider mum of the following: tion of the practitioner care of the resident. entative information including ve information actions or precautions for expropriate. care plan goals; sary information, including a 's discharge summary, 3.21(c)(2) as applicable, and tation, as applicable, to ensure transition of care. IT is not met as evidenced exview, clinical record review ent review, it was determined failed to evidence that all ation was provided to the 5 of 37 residents in the survey #20, #24, #5, #40, and #64. failed to evidence that all ation was sent to the hospital as facility initiated transfer to	F	622	2. How will the facility identify other residents having the potential to be affected by the same deficient practice? Facility will audit Resident's that were discharged/transferred within the last 30 days to ensure that the transfer documentation has been forwarded to the receiving facility and appropriately documented in the Resident's facility medical record.	11/16	/2018

2. The facility staff failed to evidence that all

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

PRINTED: 10/11/2018 FORM APPROVED OMB NO. 0938-0391

AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		49E075	B. WING		10	10410040
SKYLIN	PROVIDER OR SUPPLIER E TERRACE CONV H	OME		STREET ADDRESS, CITY, STATE, ZII PO BOX 558 WOODSTOCK, VA 22664	PCODE	/04/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	required document upon Resident #24 the hospital on 7/3. 3. The facility staff required document upon Resident #5's hospital on 7/1/18. 4. The facility staff fall required information contact information contact information ongoing care, advacomprehensive care the hospital staff what transferred to the hospital staff what transferred to the hospital staff what transferred documental provided to the recefacility-initiated transfered documental upon Resident #20's the hospital on 7/26/Resident #20 was ac 5/8/18 with the diagrify hypothyroidism, ostepressure, macular didysphagia, and chro	ation was sent to the hospital 's facility initiated transfer to 1/18. failed to evidence that all ation was sent to the hospital facility initiated transfer to the failed to provide evidence that tion (including physician resident representative special instructions for nee directives and e plan goals) was provided to nen Resident #40 was pospital on 8/16/18, 8/18/18, ailed to evidence that all ation and information was siving provider for a sfer on 07/08/18 for Resident	F 62	3. What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur? DON and/or Designee has created a transfer/discharge form to include: 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. Special instructions or precautions for ongoing care. E. Care Plan Goals.		6/2018

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Event ID; R9RL11

Facility ID: VA0226

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	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CON PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			COMPLETED			
		49E075	B. WING	·		10/	04/2018
	PROVIDER OR SUPPLIER TERRACE CONV H	OME		P	TREET ADDRESS, CITY, STATE, ZIP CODE O BOX 558 OODSTOCK, VA 22664		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 622	quarterly assessment Reference Date) or coded as being more make daily life decoded. A review of the clin "Transfer/Discharg and signed by the placement by (facility)? So "rocks on chest need to rule out my What efforts were resident's needs? assess s/s. What services will to better meet the diagnostics for chest had a review of the clin notes dated 7/26/1 documented, "Rest shortness of Breat (respirations) 132/5 (rate) 92-104 90-92 (liters of oxygen. Restand of the clin notes of the clin notes dated 7/26/1 documented, "Rest shortness of Breat (respirations) 132/5 (rate) 92-104 90-92 (liters of oxygen. Restand of the clin notes of oxygen. Restand of the clin notes dated 7/26/1 documented, "Restand of the clin notes of Breat (respirations) 132/5 (rate) 92-104 90-92 (liters of oxygen. Restand of the clin notes of oxygen. Restand of the clin notes of the clin notes of Breat (respirations) 132/5 (rate) 92-104 90-92 (liters of oxygen. Restand of the clin notes of oxygen. Restand of the clin notes of the clin notes of Breat (respirations) 132/5 (rate) 92-104 90-92 (liters of oxygen. Restand of the clin notes of oxygen. Restand of the clin notes of the	ent with an ARD (Assessment of 8/13/18. The resident was oderately impaired in ability to isions. ical record revealed a record form dated 7/26/18 obysician on 8/1/18 that	F	622	F. All other necessary information including a discharge summary. The transfer/discharge form will be sent to the receiving facility and maintained within the Resident's facility medical record. DON and/or designee will educated all licensed nurses on the discharge/transfer process.		11/16/201
	rhonchi, wheezing, spoke with MD (mo {sic} to send reside (evaluation). This (hospital) ED (eme	audible wheezing. This writer edical doctor) and was direct ent to (hospital) for eval writer contacted 911 and ergency department). This OA (power of attorney), will					

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			PF	RINTED: 10/11/2018
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FORM APPROVED
STATEMEN'	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
_		49E075	B. WING			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S		10/04/2018
SKYLINI	E TERRACE CONV HO	DME		PO BOX 558 WOODSTOCK, VA 226		
(X4) ID PREFIX TAG	! (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PL X (EACH CORRECT CROSS-REFERENC	AN OF CORRECTION VE ACTION SHOULD E ED TO THE APPROPRI FICIENCY)	BE COMPLETION DATE
	A nurses note dated documented, "reside (intensive care unit) Further review of the reveal any evidence any, was sent to the On 10/3/18 at 1:18 p conducted with RN (was asked to describ hospital staff when a hospital. RN #1 stat the residents' MAR (record), TAR (treatm and a face sheet. Waresidents' comprehe stated, "They don't in how nurses evidence hospital staff, RN #1 document the information. On 10/3/18 at 1:59 p staff member) #2 (the presented a blank for Record" (blank) that by the system when the transfers. ASM #2 sisupposed to fill the forthe hospital each time. The form documente regarding: resident in and insurance inform (allergies and advance) hysician/representated diagnoses, last vital staff.	ent is at (hospital) ICU will continue to monitor." c clinical record failed to of what documentation, if hospital. c.m., an interview was registered nurse) #1. RN #1 be the information provided to a resident is transferred to the ed the nurses send a copy of medication administration tent administration record) Then asked if nurses provide nsive care plan goals, RN #1 formally go." When asked the information provided to stated nurses usually ation provided in a nurse's c.m., ASM (administrative e director of nursing) rm titled, "Transfer Discharge she stated is auto-populated they print it for hospital tated the nurses are orm out and send the form to e a resident is transferred. d sections to be completed formation (demographics ation), other information	F		acility is ake cions hee will rs x3 hat all tation e sults to	11/16/2018

ambulation, bladder, bowel and feeding. The

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI		NSTRUCTION		TE SURVEY MPLETED	
		49E075	B. WING			10/	10/04/2018	
	PROVIDER OR SUPPLIER TERRACE CONV HO	DME		РО ВО	T ADDRESS, CITY, STATE, ZIP CODE DX 558 DSTOCK, VA 22664	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D 8E	(X5) COMPLETION DATE	
F 622	complete regarding goals. ASM #2 state completed and sent residents' MAR, TA progress notes and tests]. ASM #2 state report to hospital state facility staff could evinformation was progreach resident was the could only provistated the nurses decompleted transfer they are completed. A review of the facil Policy" documented determined that a redischarged, based oneeds can be met, stransfer/discharge, supporting rationale maintained in the metransfer or discharge document: Reason notice to resident and Discharge plans and "When a transfer or facility staff will send limited to the following EMAR/TAR [electron record/treatment and Transfer/Discharge Progress Notes; MEResults; Any other of the state of	ment a section for nurses to comprehensive care plan ed the form is supposed to be to the hospital along with R, advance directives, last any relevant labs [laboratory ed the nurses also call a aff. When asked how the vidence all required evided to hospital staff when ransferred, ASM #2 stated ide this blank form. ASM #2 to not make a copy of the discharge form to evidence	F 6	22				
		clude requirement for						

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY IPLETED
		49E075	B. WING			10/	04/2018
ŀ	PROVIDER OR SUPPLIER TERRACE CONV HO	DME		P	TREET ADDRESS, CITY, STATE, ZIP CODE O BOX 558 /OODSTOCK, VA 22664	<u>, 10,</u>	0 112010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	8E	(X5) COMPLETION DATE
F 622	sending the comprete the facility could not other required documents sent either. On 10/3/18 at 5:12 (Administrative State and Director of Nur	phensive care plan goals and tevidence that any of the amentation listed in the policy p.m., the ASM #1 and ASM #2 ff Members - the Administrator sing, respectively) were made ps. No further information was	F6	22			
	required documents upon Resident #24' the hospital on 7/31 Resident #24 was a 6/4/12 with the diag diabetes, anxiety, h depression, cerebra most recent MDS (I admission assessm Reference Date) of coded as being cog daily life decisions. A review of the clinic	admitted to the facility on noses of but not limited to					
	and signed by the p documented the foll What specific reside met by (facility)? W (signs/symptoms) o congestion.	hysician on 8/31/18 that lowing:					

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Facility ID: VA0226

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	TIPLE CONSTRUCTION		(X3) DATE SUR COMPLETE	
		49E075	B. WING			10/04/20)18
	PROVIDER OR SUPPLIER TERRACE CONV HO	DME		STREET ADDRESS, CITY, STATE, 2 PO BOX 558 WOODSTOCK, VA 22664	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROPE	BE COM	(X5) PLETION DATE
F 622	raise O2 saturation What services will to better meet the re (intravenous) abx (a r/t (related to) acute studies. A review of the clini notes dated 7/26/18 "Resident left with E McDonalds {sic} bre had no issues with drinking her milksha resident had a coug her shake. Residen milky substance an VS (vital signs) Tem 108/60 P (pulse) 12 (oxygen) is 76%. R of oxygen. Vital sig A nurses note dated documented, "Resid audible congestion vocalizations. Voice underwater. Reside this time. While spe moved her oxygen a wear it. Spoke with obtained to send re- department] for eva-	D2 (oxygen) applied, unable to be offered by receiving facility esident's needs? IV antibiotic), diagnostic abilities econcerns, swallowing cal record revealed nurses at 2:30 PM that documented, Brother {sic} to have lunch at other reported that resident ther meal until she was take. Brother stated that phing episode while drinking at returned to facility with white d chunks of food on her shirt. In p. 98.2 BP (blood pressure) to R (respirations) 20 and O2 tesident started on 2L (liters) as to be monitored."	F 6	522			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X:	3) DATE SURVEY COMPLETED
		49E075	B. WING			10/04/2018
	PROVIDER OR SUPPLIER E TERRACE CONV HO	DME		STREET ADDRESS, CITY, STATE, ZIP C PO BOX 558 WOODSTOCK, VA 22664	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	
F 622	A nurses note dated documented, "Rece [emergency room] {sic} admitted to cri aspiration pneumor. Further review of the reveal any evidence any, was sent to the On 10/3/18 at 1:18 conducted with RN was asked to descr hospital staff when hospital. RN #1 stathe residents' MAR record), TAR (treatment a face sheet. A residents' comprehistated, "They don't how nurses evidence hospital staff, RN # document the informate. On 10/3/18 at 1:59 staff member) #2 (to presented a blank for Record" (blank) that by the system where transfers. ASM #2 supposed to fill the the hospital each time The form document and insurance information (allergies and advant physician/represent	d 7/26/18 at 8:21 p.m., eived a call from ER nurse that resident is been tical care (hospital) for nia." The clinical record failed to e of what documentation, if e hospital. The p.m., an interview was (registered nurse) #1. RN #1 ibe the information provided to a resident is transferred to the sted the nurses send a copy of (medication administration ment administration record) When asked if nurses provide ensive care plan goals, RN #1 normally go." When asked to the information provided to 1 stated nurses usually mation provided in a nurse's The p.m., ASM (administrative he director of nursing) form titled, "Transfer Discharge the she stated is auto-populated in they print it for hospital stated the nurses are form out and send the form to me a resident is transferred. The deduction is transferred is transferred. The deduction is transferred is transferred. The deduction is transferred is transferred in the deduction	F 62	22		

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Event ID: R9RL11

Facility ID: VA0226

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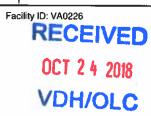
PRINTED: 10/11/2018 **FORM APPROVED** OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	TIPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
	_	49E075	B. WING_		1	0/04/2018
	PROVIDER OR SUPPLIER TERRACE CONV HO	DME		STREET ADDRESS, CITY, STATE, ZIP CO PO BOX 558 WOODSTOCK, VA 22664		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 622	"relevant informatio ambulation, bladder form failed to docum complete regarding goals. ASM #2 stat completed and sent residents' MAR, TAI progress notes and stated the nurses al staff. When asked evidence all require hospital staff when a ASM #2 stated she form. ASM #2 stated she form. ASM #2 stated copy of the complet evidence they are completed to the completed and Director of Nurse ambulation."	n" regarding behavior(s), r, bowel and feeding. The nent a section for nurses to comprehensive care plan ed the form is supposed to be to the hospital along with R, advance directives, last any relevant labs. ASM #2 lso call a report to hospital how the facility staff could d information was provided to each resident was transferred, could only provide this blank ed the nurses do not make a ed transfer discharge form to ompleted. PM the ASM #1 and ASM #2 f Members - the Administrator sing, respectively) were made s. No further information was	F 62	22		
	required documenta	failed to evidence that all ation was sent to the hospital facility initiated transfer to the		(5)		
	6/25/18 with the diagepilepsy, cerebrovas disease, Alzheimer's bladder, diabetes, d thrombosis. The mediate Data Set) was a qua ARD (Assessment F	mitted to the facility on gnoses of but not limited to scular disease, stroke, kidney is disease, neurogenic ementia, and deep vein lost recent MDS (Minimum larterly assessment with an Reference Date) of 7/13/18.				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY IPLETED
		49E075	B. WING			10/	04/2018
	AME OF PROVIDER OR SUPPLIER KYLINE TERRACE CONV HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 558 WOODSTOCK, VA 22664				
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 622	A review of the clir "Transfer/Discharg and signed by the documented the form What specific resident by (facility)? a able to obtain vitals What efforts were resident's needs? blood sugar. What services will to better meet the diagnostics, stabili A review of the clir notes dated 7/1/18 "Temp (temperatur (Respirations) 18, Resident started werest of vitals. M.D. gave order to send POA (power of attoresident at ER. So 0119 (1:19 AM) to approx. (approximation (certified nursing aduring this time." Further review of the reveal any evidence any, was sent to the On 10/3/18 at 1:18	g daily life decisions. Inical record revealed a ge Policy" form dated 7/1/18 physician on 8/1/18 that ollowing: Ident needs are not able to be 20 min (minute) seizure, not is. Offered at (facility) to meet the attempted vitals, obtained be offered by receiving facility resident's needs? stat meds, is at 1:29 AM that documented, is at 1:29 AM that documented and it oe ER (emergency room). Forney) notified and will meet quad here and transported at (hospital). Seizure lasted ately) 20 minutes. CNA is sistant) stayed with resident in the clinical record failed to be of what documentation, if e hospital. P.m., an interview was	F6	22			

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Facility ID: VA02

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	45	PLE CONSTRUCTION G		TE SURVEY MPLETED
		49E075	B. WING _		10	/04/2018
	PROVIDER OR SUPPLIER ETERRACE CONV HO	OME		STREET ADDRESS, CITY, STATE, ZIP COD PO BOX 558 WOODSTOCK, VA 22664		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(XS) COMPLETION DATE
F 622	was asked to describospital staff when hospital. RN #1 state residents' MAR record), TAR (treatrand a face sheet. It residents' comprehestated, "They don't how nurses evidenthospital staff, RN # document the informate. On 10/3/18 at 1:59 staff member) #2 (t presented a blank f Record" (blank) that by the system wher transfers. ASM #2 supposed to fill the the hospital each time The form document regarding: resident and insurance infor (allergies and advarphysician/represent diagnoses, last vital "relevant informatio ambulation, bladder form failed to document regarding. ASM #2 state complete regarding goals. ASM #2 state completed and sent residents' MAR, TAI progress notes and stated the nurses all staff. When asked evidence all require	ribe the information provided to a resident is transferred to the ated the nurses send a copy of (medication administration ment administration record). When asked if nurses provide ensive care plan goals, RN #1 normally go." When asked to the information provided to 1 stated nurses usually mation provided in a nurse's p.m., ASM (administrative he director of nursing) form titled, "Transfer Discharge to she stated is auto-populated in they print it for hospital stated the nurses are form out and send the form to me a resident is transferred. It is ted sections to be completed information (demographics mation), other information	F 62			

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Event ID: R9RL11

Facility ID: VA0226

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		49E075	B. WING _		10	/04/2018		
	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		STREET ADDRESS, CITY, STATE, ZIP CO PO BOX 558 WOODSTOCK, VA 22664					
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 622	ASM #2 stated she form. ASM #2 state copy of the comple evidence they are of the complex evidence they are of the finding provided by the end of the finding contact information contact information contact information contact information ongoing care, advacomprehensive can the hospital staff witransferred to the h8/27/18 and 9/7/18 Resident #40 was a 9/27/06. Resident were not limited to and obesity. Resident were not limited to and obesity. Resident was the coded the resident moderately impaired the resident was trafollowing dates: -8/16/18 for an ank -8/18/18 for a channesident shaking ar	could only provide this blank ed the nurses do not make a sted transfer discharge form to completed. PM the ASM #1 and ASM #2 ff Members - the Administrator raing, respectively) were made gs. No further information was dof the survey. failed to provide evidence that ation (including physician president representative plan goals) was provided to then Resident #40 was ospital on 8/16/18, 8/18/18, admitted to the facility on #40's diagnoses included but diabetes, urinary tract infection ent #40's most recent MDS plan a quarterly assessment with ent reference date) of 8/12/18, is cognition as being d. If #40's clinical record revealed ansferred to the hospital on the le evaluation after a fall. ge in condition involving the lad a change in vital signs. Responsive episode.	F 62					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	49E075	B. WING		10	/04/2018	
	OME	PC) BOX 558			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE	
	- -	F 622				
(including nurses' not reveal evidence the required inform nurses' notes did nowas provided. On 10/3/18 at 1:18 conducted with RN was asked to describe hospital staff when hospital. RN #1 state residents' MAR record), TAR (treatment and a face sheet (conformation, represent and advanced directly provide residents' of goals, RN #1 stated When asked how not information provide stated nurses usual	notes) for each transfer failed that the facility staff provided ation to hospital staff. The ot document what information p.m., an interview was (registered nurse) #1. RN #1 ribe the information provided to a resident is transferred to the ated the nurses send a copy of (medication administration ment administration record) containing physician, contact entative contact information ctives). When asked if nurses comprehensive care pland, "They don't normally go." nurses evidence the do to hospital staff, RN #1 lly document the information					
staff member) #2 (t presented a blank a "Transfer Discharge stated the nurses a and send the form resident is transfer sections to be com- information (demog- information), other advanced directives contact information chief complaint and regarding behaviore	he director of nursing) auto populated form titled, e Record (blank)." ASM #2 are supposed to fill the form out to the hospital each time a red. The form documented pleted regarding: resident graphics and insurance information (allergies and s), physician/representative , diagnoses, last vital signs, I "relevant information" (s), ambulation, bladder, bowel					
	PROVIDER OR SUPPLIER E TERRACE CONV HO SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa Further, review of f (including nurses' r to reveal evidence the required inform nurses' notes did n was provided. On 10/3/18 at 1:18 conducted with RN was asked to describospital staff when hospital. RN #1 sta the residents' MAR record), TAR (treati and a face sheet (o information, repres and advanced direct provide residents' of goals, RN #1 stated When asked how n information provide stated nurses usual provided in a nurse On 10/3/18 at 1:59 staff member) #2 (to presented a blank a "Transfer Discharge stated the nurses a and send the form resident is transfer sections to be com- information (demog- information), other advanced directives contact information chief complaint and regarding behaviors	A9E075 PROVIDER OR SUPPLIER E TERRACE CONV HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 23 Further, review of Resident #40's clinical record (including nurses' notes) for each transfer failed to reveal evidence that the facility staff provided the required information to hospital staff. The nurses' notes did not document what information	PROVIDER OR SUPPLIER E TERRACE CONV HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 23 Further, review of Resident #40's clinical record (including nurses' notes) for each transfer failed to reveal evidence that the facility staff provided the required information to hospital staff. The nurses' notes did not document what information was provided. On 10/3/18 at 1:18 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked to describe the information provided to hospital. RN #1 stated the nurses send a copy of the residents' MAR (medication administration record), TAR (treatment administration record) and a face sheet (containing physician, contact information, representative contact information and advanced directives). When asked if nurses provide residents' comprehensive care plan goals, RN #1 stated, "They don't normally go." When asked how nurses evidence the information provided to hospital staff, RN #1 stated nurses usually document the information provided in a nurse's note. On 10/3/18 at 1:59 p.m., ASM (administrative staff member) #2 (the director of nursing) presented a blank auto populated form titled, "Transfer Discharge Record (blank)." ASM #2 stated the nurses are supposed to fill the form out and send the form to the hospital each time a resident is transferred. The form documented sections to be completed regarding: resident information (demographics and insurance information, other information (allergies and advanced directives), physician/representative contact information, diengoses, last vital signs, chief complaint and "relevant information" regarding behavior(s), ambulation, bladder, bowel	PROVIDER OR SUPPLIER E TERRACE CONV HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUIL). REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 23 Fruther, review of Resident #40's clinical record (including nurses' notes) for each transfer failed to reveal evidence that the facility staff provided the required information to hospital staff. The nurses' notes did not document what information was provided. On 10/3/18 at 1:18 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital astaff when a resident is transferred to the hospital staff when a resident information record), TAR (treatment administration record), TAR (treatment administration record), TAR (treatment administration record) and a face sheet (containing physician, contact information, representative contact information and advanced directives). When asked if nurses provide residents' comprehensive care plan goals, RN #1 stated, "They don't normally go." When asked how nurses evidence the information provided to hospital staff, RN #1 stated nurses shoet. On 10/3/18 at 1:59 p.m., ASM (administrative staff member) #2 (the director of nursing) presented a blank auto populated form titled, "Transfer Discharge Record (blank)." ASM #2 stated the nurses are supposed to fill the form out and send the form to the hospital seach time a resident is transferred. The form documented sections to be completed regarding: resident information (demographics and insurance information, diagnoses, last vital signs, chief complaint and "relevant information" regarding behavior(s), physician/representative contact information, diagnoses, last vital signs, chief complaint and "relevant information" ladder, bowel	PROVIDER OR SUPPLIER E TERRACE CONV HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 23 Further, review of Resident #40's clinical record (including nurses' notes) for each transfer failed to reveal evidence that the facility staff provided the required information to hospital staff. The nurses' notes did not document what information was provided. On 10/3/18 at 1:18 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital staff when a resident is transferred to the hospital staff when a resident is framferred to the hospital staff when a resident is framferred to the hospital staff when a resident is framferred to the hospital staff when a resident is framferred to the hospital staff when a resident is framferred to the hospital staff when a resident is framferred to the hospital staff when a resident is framferred to the hospital staff when a resident is framferred to the hospital staff when a resident is transferred. The horn document the information provided to hospital staff when a resident is transferred. The horn document the information provided to hospital staff, RN #1 stated murses and the horn to hospital staff, RN #1 stated murses note. On 10/3/18 at 1:59 p.m., ASM (administrative staff member) #2 (the director of nursing) presented a blank auto populated form titled, "Transfer Discharge Record (blank)." ASM #2 stated the nurses are supposed to fill the form out and send the form to the hospital each time a resident is transferred. The form documented sections to be completed regarding: resident information (demographics and insurance information, diagnoses, last vital signs, chief complaint and "relevant information, bladder, bowel	

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Event ID: R9RL11

Facility ID: VA0226



PRINTED: 10/11/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49E075	B. WING			10/	04/2018
	PROVIDER OR SUPPLIER ETERRACE CONV H			STREET ADDRESS, CITY, STATE, ZIP C PO BOX 558 WOODSTOCK, VA 22664	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 622	section for nurses comprehensive can the form is suppose the hospital along advanced directive relevant labs. ASN a report to hospital facility staff could einformation was preeach resident was she could only prosestated the nurses of discharge records completed. On 10/3/18 at 5:07 administrator) and the above concerns. No further information to facility-initiated transprovided to the receptacility-initiated transprovide	to complete regarding re plan goals. ASM #2 stated ed to be completed and sent to with residents' MAR, TAR, s, last progress notes and any #2 stated the nurses also call staff. When asked how the evidence all required ovided to hospital staff when transferred, ASM #2 stated vide this blank form. ASM #2 do not copy completed transfer to evidence they are p.m., ASM #1 (the ASM #2 were made aware of the evidence that all ation and information was eiving provider for a sefer on 07/08/18 for Resident admitted to the facility on soes that included but were entia (1), depressive disorder hypertension (4). Post recent MDS (minimum data sessment with an ARD ence date) of 09/21/18, coded coring a 12 on the brief	F6	322			
	interview for menta	I status (BIMS) of a score of 0 derately impaired of cognition					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		ONSTRUCTION		TE SURVEY MPLETED
		49E075	B. WING			10	/04/2018
	PROVIDER OR SUPPLIER	OME		PO B	EET ADDRESS, CITY, STATE, ZIP CODE BOX 558 DDSTOCK, VA 22664	, ,0	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 622	for making daily de The nurse's "Progr documented, "07/0 SOB (short of brea (sic.) cough, O@ (c) 92% (percent) on 2 (nasal cannula). T 73. R (respiration) 100/62 (one hundre (Name of Physiciar like her sent to ER evaluation" At 1 "Progress Notes" fo "Sent to E.R. (eme (evaluate) and trea	_	F	522			
	EHR (electronic he documentation that contact information contact information ongoing care, adva comprehensive car the hospital staff witransferred to the hospital staff witransferred with RN was asked to describospital staff when hospital. RN #1 stathe residents' MAR record), TAR (treating and a face sheet. It residents' comprehension that is the resident that it is t	at # 64's clinical record and alth record) failed to evidence the facility provided physician, resident representative, special instructions for nce directives and e plan goals were provided to nen Resident #64 was ospital on 07/08/18. p.m., an interview was (registered nurse) #1. RN #1 ribe the information provided to a resident is transferred to the ated the nurses send a copy of (medication administration ment administration record) When asked if nurses provide ensive care plan goals, RN #1 normally go." When asked					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	IPLE CONSTRUCTION NG		TE SURVEY MPLETED	
		49E075	B. WING		10	/04/2018	
	PROVIDER OR SUPPLIER	•	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 558 WOODSTOCK, VA 22664			10/04/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 622	hospital staff, RN document the info note. On 10/3/18 at 1:59 staff member) #2 presented a blank "Transfer Discharg stated the nurses and send the form resident is transfer sections to be con information (demoinformation), other advance directives contact information chief complaint an regarding behavior and feeding. The section for nurses comprehensive can the form is suppose the hospital along advance directives relevant labs. ASI a report to hospital facility staff could dinformation was preach resident was she could only prostated the nurses of discharge records completed. On 10/093/18 at a (administrative staff)	age 26 Ince the information provided to #1 stated nurses usually rmation provided in a nurse's p.m., ASM (administrative (the director of nursing) auto populated form titled, ge Record (blank)." ASM #2 are supposed to fill the form out to the hospital each time a rred. The form documented apleted regarding: resident graphics and insurance information (allergies and s), physician/representative in, diagnoses, last vital signs, d "relevant information" r(s), ambulation, bladder, bowel form failed to document a to complete regarding are plan goals. ASM #2 stated sed to be completed and sent to with residents' MAR, TAR, s, last progress notes and any M #2 stated the nurses also call I staff. When asked how the evidence all required rovided to hospital staff when transferred, ASM #2 stated vide this blank form. ASM #2 do not copy completed transfer to evidence they are	F 62	22			

PRINTED: 10/11/2018 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		49E075	B. WING _		10/	04/2018
	PROVIDER OR SUPPLIER TERRACE CONV HO	DME		STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 558 WOODSTOCK, VA 22664	, 1 <u>0</u> /	04/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	8E	(X5) COMPLETION DATE
F 622		_	F 68	22		
	References: (1) A loss of brain further diseases. It affects in judgment, and behas obtained from the whittps://medlineplus. (2) Depression may blue, unhappy, mise Most of us feel this short periods. Clinic disorder in which feel	unction that occurs with certain memory, thinking, language, avior. This information was rebsite: gov/ency/article/000739.htm. The described as feeling sad, erable, or down in the dumps. way at one time or another for cal depression is a mood elings of sadness, loss, anger, re with everyday life for weeks				
	or more. This information website: https://medlineplus.id (3) Fear. This information website: https://www.nlm.nih #summary.	mation was obtained from the gov/ency/article/003213.htm. mation was obtained from the .gov/medlineplus/anxiety.html				
	obtained from the w https://www.nlm.nih essure.html.	.gov/medlineplus/highbloodpr Comprehensive Care Plan	F 65	56		
	implement a compre care plan for each re resident rights set for	hensive Care Plans acility must develop and ehensive person-centered esident, consistent with the orth at §483.10(c)(2) and ncludes measurable				

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Event ID: R9RL11

Facility ID: VA0226 RECEIVE n nuation sheet Page 28 of 62



DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/11/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 49E075 B. WING NAME OF PROVIDER OR SUPPLIER 10/04/2018 STREET ADDRESS, CITY, STATE, ZIP CODE SKYLINE TERRACE CONV HOME **PO BOX 558** WOODSTOCK, VA 22664 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID (X5)PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG COMPLÉTION TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 656 Continued From page 28 F 656 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must F656 describe the following -(i) The services that are to be furnished to attain 1. How will corrective or maintain the resident's highest practicable action be accomplished physical, mental, and psychosocial well-being as for those residents required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required found to be affected by under §483.24, §483.25 or §483.40 but are not the deficient practice? provided due to the resident's exercise of rights under §483.10, including the right to refuse A privacy bag is being treatment under §483.10(c)(6). utilized on Resident #53's 10/4/2018 (iii) Any specialized services or specialized rehabilitative services the nursing facility will catheter bag as stated in provide as a result of PASARR the Resident's care plan. recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its Call bell was placed rationale in the resident's medical record. 10/3/2018 within reach for Resident (iv)In consultation with the resident and the #15 as stated in the resident's representative(s)-(A) The resident's goals for admission and Resident's care plan. 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, facility document review and clinical record review, it

was determined that facility staff failed to follow

	OF CORRECTION	IDENTIFICATION NUMBER:		ING		MPLETED
		49E075	B. WING		10	0/04/2018
	PROVIDER OR SUPPLIER TERRACE CONV HO	OME		STREET ADDRESS, CITY, STATE PO BOX 558 WOODSTOCK, VA 22664		
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F 656	residents in the sur and # 15. 1. The facility staff comprehensive car catheter collection is 2. The facility staff comprehensive car bell. The findings include 1. The facility staff comprehensive car catheter collection is Resident # 53 was 11/07/17 with diagn not limited to: benig gout (2), hemiplegia Resident # 53's moset), an annual asse (assessment refere Resident # 53 as so interview for mental - 15, 7 (seven) - bei cognition for making 53 was coded as retotal assistance of of daily living. Section coded Resident # 5 catheter. On 10/02/18 at apprentice of 10/02/18 at apprent	care plan for two of 24 vey sample, Resident # 53 failed to follow the e plan for Resident # 53's bag. failed to follow the e plan for Resident # 15's call e: failed to follow the e plan for Resident # 15's call	F6	2. How will the facilitidentify other resider having the potential to be affected by the saideficient practice? DON and/or designee audit residents with a indwelling catheter caplan to ensure that the catheter is being appropriately placed within the privacy bag DON and/or designee audit residents with care plan to have call within reach to ensure care plan compliance.	nts to me will n are e will h a bell	10/4/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		49E075	B. WING			10/	04/2018	
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 558 WOODSTOCK, VA 22664							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 656	conducted of Reside catheter collection A-side bed, next to lying in bed. Reside bag was observed the entrance side of was hanging outsid # 53's catheter collection hallway. On 10/03/18 at approproximately 11:3 conducted of Reside catheter collection A-side bed, next to lying in bed and the hanging off the side entrance side of the could be seen from On 10/03/18 at approbservation was concluded by the collection bag was in the A-side the room, lying in becollection bag was of bed, on the entracatheter bag was heag. Resident # 53' be seen from hallway. Based on the MDS severely impaired of could not be intervited been as the collections of the collec	lent # 53 and Resident 53's bag. Resident # 53 was in the the entrance of the room, ent #53's catheter collection hanging off the side of bed, on if the room. The catheter bag le of the privacy bag. Resident ection bag could be seen from eroximately 7:36 a.m., at 6 a.m., observations were lent # 53 and Resident 53's bag. Resident # 53 was in the the entrance of the room, a catheter collection bag of bed in a privacy bag on the eroom, off the floor and it hallway. I roximately 3:10 p.m., an and the entrance of the entrance of ed. Resident # 53 and eter collection bag. Resident # 59 and eter collection bag catheter collection bag could as coding of Resident # 53 being of cognition, Resident # 53 being of cognition, Resident 53's	F	356	3. What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur? DON and/or Designee will educate nursing staff to follow the Resident care plan for call bell placement and catheter collection bags.		10/25/201	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		49E075	B. WING	i		10/	04/2018
	PROVIDER OR SUPPLIER E TERRACE CONV HO	OME		P	TREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 558 VOODSTOCK, VA 22664		101
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	with a revision date Focus: (Resident# catheter. 16 FR (F balloon r/t (related t "Interventions it doo (Resident # 53) has catheter. Position of the level of the blade entrance room doo indicated." On 10/03/18 3:28 p conducted with LPN 2. When asked wh collection bag and t stated, 'In front of the she entered Reside LPN # 2 stated, "I sin the privacy bag of was out of sight." When asked who collection bag and to the privacy bag of was out of sight." When asked who can't be seen. "Who purpose of the care you what you need documented on the needs to be followed a was then asked indwelling catheter that documented, "Chas 16 FR (French) catheter bag and tubladder and away for Cover with privacy 106/21/2018." When	age 31 be care plan for Resident # 53 of 06/21/2018 documented, 53) has indwelling Foley rench) with 10 ml (milliliter to) urinary retention." Under cumented, "CATHETER: a 16 FR (French) Foley catheter bag and tubing below lider and away from the r. Cover with privacy bag as solved. "In the catheter ubing was located, LPN # 2 he door." When asked why ent # 53's room at 3:24 p.m., aw the catheter bag was not completely and I replaced so it when asked about the dent's catheter collection bag, he bag should in a privacy so it the land LPN # 2 stated, "It tells to do." When asked if it is care plan is it something that d, LPN # 2 stated, "Yes." LPN to review Resident # 53's care plan and the intervention CATHETER: (Resident # 53) Foley catheter. Position bing below the level of the room the entrance room door. The cash of the care plan for the term was being followed, LPN here was being followed.	F	656	4. How does the facility plan to monitor it's performance to make sure that the solutions are sustained? DON and/or Designee will audit Residents with a care plan for indwelling catheter x3 weeks to ensure continued compliance with the care plan. DON and/or Designee will audit Residents with a care plan on call bell placement x3 weeks to ensure continued compliance with the care plan. DON will report results to the QA committee. Findings and results will be reflected in the QA minutes.		11/16/2018

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Facility ID: VA0226 RECEIVE tinuation sheet Page 32 of 62



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49E075	B. WING			10/04/2018	
	PROVIDER OR SUPPLIER TERRACE CONV HO	OME	·	РО ВО	T ADDRESS, CITY, STATE, ZIP CODE IX 558 DSTOCK, VA 22664		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	The facility's policy documented, "Purp arranged into three Plan Problem, Care Interventions which individualized care resident at (Name of "Procedure" it docu utilize Plan of care care is appropriate On 10/03/18 at app (administrative staff administrator and Awere made aware of the work of t	"Care Plan Policy" lose: Nursing care plans are parts which includes Care e Plan Goal, and Care Plan e should be utilized to provide according to the needs of the of Nursing Home)." Under limented, "Facility staff should accordingly to ensure resident and follows plan of care." Inoximately 5:00 p.m., ASM f member) # 1, the lise SM # 2, director of nursing of the findings. It is information was	F	556			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		49E075	B. WING			10/	04/2018
NAME OF PROVIDER OR SUPPLIER SKYLINE TERRACE CONV HOME		DME		STREET ADDRESS, CITY, STATE, ZIP PO BOX 558 WOODSTOCK, VA 22664	CODE		
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F 656	https://medlineplus. (4) High blood pres obtained from the w	gov/paralysis.html.	F€	556			
	bell. Resident # 15 was 09/22/17 with diagn not limited to: aphainfarction (3) and hy Resident # 15's moset), an annual asset	admitted to the facility on loses that included but were sia (1), dysphagia (2), cerebral pertension (4). st recent MDS (minimum data essment with an ARD					
	Resident # 15 as so interview for mental - 15, 12 - being more for making daily decoded as totally depone staff member for the constant of the was clean, nonverbal with motion) of his RUE Observation of the cattached to the upp sheet covering the constant of the constant of the cattached. When F	coring a 12 on the brief status (BIMS) of a score of 0 derately impaired of cognition cisions. Resident # 15 was bendent with the assistance of or activities of daily living. 7 p.m., Resident # 15 was in his bed, appeared neat and th decreased ROM (range of (right upper extremity). It call bell revealed it was er left corner of the fitted mattress above Resident # 15 was asked to the the call bell, he was unable					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		49E075	B. WING			10/04/2018		
	PROVIDER OR SUPPLIER TERRACE CONV HO	OME		STREET ADDRESS, CITY, STAT PO BOX 558 WOODSTOCK, VA 22664	,			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED	ACTION SHOULD	BE	(X5) COMPLETION DATE	
F 656	On 10/03/18 at 2:04 his room reclined in his bed. Observation revealed the call bethe bed. When Recreach for and activate to locate it. The comprehensive dated 09/22/2017 of (Resident # 15) has living) self-care per right sided hemipar contracture of right it documented, "Embell to call for assis 09/22/2017." On 10/03/18 at 2:11 conducted with CN.2 and # 3. When a resident's call bell, should be within restand the placement acknowledged Resnext to his bed and of Resident # 15's breach of Resident # brought Resident # brought Resident # having lunch." CN.4 On 10/03/18 at 2:17 conducted with CN.7 Conducted with CN.7 Conducted with CN.7 Conducted with CN.7 CN.4 CN.4 4 was asked CNA # 4 wa	A p.m., Resident # 15 was in a Gerri chair sitting next to on of Resident # 15's bed ell was lying in the middle of sident # 15 was asked to ate the call bell, he was unable care plan for Resident # 15 locumented, "Focus. an ADL (activities of daily formance deficit r/t (related to) esis age, immobility and hand." Under "Interventions" courage the resident to use tance. Date initiated: 1 p.m., an interview was A (certified nursing assistant) # sked about the placement of a CNAs # 2 and # 3 stated, "It sident's reach." CNAs # 2 and d to observe Resident # 15 of his call bell. They ident # 15 was in a Gerri chair the call bell was in the middle bed and that it was not within the call bell was in the middle bed and that it was not within a 15. When asked if they had 15 back to his room from the call bell was in the middle bed and that it was not within a 15. When asked about the dent's call bell, CNA #4 stated, bell is within his reach." After ion of Resident # 15's call bell if Resident # 15 could reach a stated. "No." When asked	F 6	56				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	90	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		49E075	B. WING			10/04/2018	
	PROVIDER OR SUPPLIER ETERRACE CONV HO	OME		STREET ADDRESS, CITY, STATE, ZI PO BOX 558 WOODSTOCK, VA 22664			
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F 656	if she brought Resifollowing lunch, CN him in the room I proved the call bell hand on it to make no idea how it was Resident # 15 had to the middle of the 4 stated, "No." On 10/03/18 3:28 producted with LPN 2. When asked to care plan, LPN # stated to do." When the care plan is it stollowed, LPN stated the observations LPN # 2 was then a 15's ADL care plan documented, "Encoto call for assistant When asked if the call bell was being to call for assistant when asked if the call bell was being to 10/03/18 at app (administrative stafadministrator and A were made aware of the brain that control hard for you to read mean to say) This is the website:	dent # 15 back into his room A # 4 stated, "When I brought at him next to the bed and over on the bed and put his sure he could reach it. I have moved." When asked if the ability to move the call bell bed from his position, CNA # I.m., an interview was N (licensed practical nurse) # describe the purpose of the ated, "It tells you what you asked if it is documented on mething that needs to be ad, "Yes." After being informed of Resident # 15's call bell, asked to review Resident # and the intervention that burage the resident to use bell e. Date initiated: 09/22/2017." care plan for Resident # 15's followed, LPN # 2 stated, "No." roximately 5:00 p.m., ASM f member) # 1, the .SM # 2, director of nursing	F 6	56			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: R9RL11

Facility ID: VA0226

If continuation sheet Page 36 of 62



PRINTED: 10/11/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER E TERRACE CONV HO		- 1	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 558 WOODSTOCK, VA 22664	100	<u>04/2018</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 657 SS=D	obtained from the whttps://www.nlm.nih sorders.html. (3) A stroke. When brain stops. A stroke attack." If blood flow few seconds, the broxygen. Brain cells damage. This inform website: https://medlineplus.gotained from the whttps://medlineplus.gotained from the whttps://www.nlm.nih.essure.html. Care Plan Timing ar CFR(s): 483.21(b)(2) A combe- (i) Developed within the comprehensive a (ii) Prepared by an ir includes but is not lir (A) The attending phenomenature (C) A nurse aide with resident. (C) A nurse aide with resident. (D) A member of foo (E) To the extent pra	order. This information was rebsite: .gov/medlineplus/swallowingdi blood flow to a part of the exist sometimes called a "brain wis cut off for longer than a cannot get nutrients and can die, causing lasting mation was obtained from the gov/ency/article/000726.htm. sure. This information was ebsite: gov/medlineplus/highbloodpr and Revision)(i)-(iii) nensive Care Plans aprehensive care plan must 7 days after completion of assessment. aterdisciplinary team, that nited to	F 656	1. How will corrective action be accomplished for those residents found to be affected by the deficient practice? The care plan for Resident #4 will be revised to include falls occurring on 10/1/2017 and 11/11/2017.	11/16/	11/16/2018	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: R9RL11

Facility ID: VA0226

OCT 2 4 2018



DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING COMPLETED 49E075 B. WING 10/04/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **PO BOX 558** SKYLINE TERRACE CONV HOME WOODSTOCK, VA 22664 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 657 Continued From page 37 F 657 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 3. What measures will or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary be put into place or team after each assessment, including both the systemic changes made comprehensive and quarterly review to ensure the deficient assessments. practice will not This REQUIREMENT is not met as evidenced reoccur? Based on staff interview, facility document review and clinical record review, it was determined that DON will educate the facility staff failed to review and/or revise the members of the nursing 11/16/2018 comprehensive care plan for one of 24 residents clinical team to ensure in the survey sample, Residents #4. that revisions are made The facility staff failed to review and/or revise to care plans following Resident #4's comprehensive care plan when the falls. resident fell on 10/1/17 and 11/11/17. 4. How does the facility plan to monitor it's The findings include: performance to make Resident #4 was admitted to the facility on sure that the solutions 7/29/13. Resident #4's diagnoses included but are sustained? were not limited to anxiety disorder, urinary tract infection and high cholesterol. Resident #4's DON and/or designee will most recent MDS (minimum data set), a quarterly monitor care plans of 11/16/2018 assessment with an ARD (assessment reference residents with falls x3 date) of 7/9/18, coded the resident's cognition as severely impaired. Section J coded Resident #4 weeks to ensure as not having any falls since the prior revisions have been assessment. completed.

Review of Resident #4's clinical record revealed

PRINTED: 10/11/2018

PRINTED: 10/11/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 49E075 B. WING 10/04/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **PO BOX 558** SKYLINE TERRACE CONV HOME WOODSTOCK, VA 22664 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 657 Continued From page 38 F 657 the resident was observed lying on the floor beside her bed on 10/1/17 and was observed lying on the floor in the bathroom on 11/11/17. Review of Resident #4's comprehensive care DON will report results to plan initiated on 5/23/16 failed to reveal the care 11/16/2018 the QA committee. plan was reviewed and/or revised for the 10/1/17 Findings and results will and 11/11/17 falls. be reflected in the QA On 10/3/18 at 2:14 p.m., an interview was minutes conducted with RN (registered nurse) #2. RN #2 confirmed residents' care plans should be reviewed after each fall. On 10/3/18 at 2:41 p.m., RN #2 confirmed she could not find evidence that Resident #4's care plan was reviewed or revised after the resident fell on 10/1/17 and 11/11/17. On 10/3/18 at 5:07 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Care Plan Policy" documented, "Purpose: Nursing care plans are arranged into the three parts which include Care Plan Problem, Care Plan Goal, and Care Plan Interventions which should be utilized to provide individualized care according to the needs of the residents at (name of facility)... Reviews to the care plan will be completed as follows: -Quarterly -Changes in the plan of care for the resident -Readmission..." No further information was presented prior to exit.

CFR(s): 483.25(i)

Respiratory/Tracheostomy Care and Suctioning

F 695

SS=D

F 695

STATEMAT OF DEPICEMENTS STATEMAT OF DEPICEMENTS AND PLAN OF CORRECTION IN PROVIDER OR SUPPLIER STATEMAT OF DEPICEMENTS AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER STATEMATORY OF DEPICEMENTS A SULDING 1, WIND STATEST ADDRESS, CITY, STATE, ZIP CODE PO BOX 58 WOODSTOCK, VA 22664 PERFOX GRACH DEPICIENTLY MUST BE PRECEDED BY VIII. TAG Continued From page 39 \$4.83.25() 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. The facility must ensure that a resident who needs 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. The facility must ensure that a resident who needs 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. The facility must ensure that a resident who needs respiratory care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care and services for one of 24 residents in the survey sample, Resident # 41. The facility staff failed to brone Resident # 41. The facility staff failed to store Resident # 41. The facility staff failed to the facility on 1228 /2008 with diagnoses that included but were not limited to heart disease (1), strail fibrillation (2), multiple sciences (3) and hypertension (4). Resident # 41 was admitted to the facility on 1228 /2008 with diagnoses that included but were not limited to heart disease (1), strail fibrillation (2), multiple sciences (3) and hypertension (4). Resident # 41 as scoring a 9 (nine) on the brief interview for mental status (BIMS) of a score of 0 - 15, 9 (nine) - being moderately impaired of	OENTE	TIMENT OF HEALTH	AND HUMAN SERVICES			PRINTE	D: 10/11/201
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- 15, 9 (nine) - being moderately impaired of cognition for making daily decisions. Resident #]	Hesident # 41 as scol	ring a 9 (nine) on the brief		January Manner.		
cognition for making daily decisions. Resident #		interview for mental s	tatus (BIMS) of a score of 0				
41 was coded as requiring limited to extensive		counition for making t	noderately impaired of		REC	FIVED	
assistance of one staff member for activities of		41 was coded as requ	uring limited to extensive		11.76.7132		
		assistance of one sta	ff member for activities of		OCT	2.4.2018	

OCT 24 2018

PRINTED: 10/11/2018 **DEPARTMENT OF HEALTH AND HUMAN SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 49E075 B. WING . 10/04/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **PO BOX 558** SKYLINE TERRACE CONV HOME WOODSTOCK, VA 22664 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) F 695 Continued From page 40 F 695 daily living. On 10/02/18 at 2:40 p.m., an observation of 3. What measures will Resident # 41's oxygen concentrator revealed it was on the left side of the bed against the wall. be put into place or The oxygen concentrator was off. Observation of systemic changes made the oxygen tubing and nasal cannula revealed it to ensure the deficient was uncovered and lying on the floor under the practice will not bed. reoccur? On 10/02/18 at 5:50 p.m., an observation of Resident # 41's oxygen concentrator revealed it DON and/or Designee 10/25/2018 was on the left side of the bed against the wall. will educate nursing staff The oxygen concentrator was off. Observation of on sanitary storage of the oxygen tubing and nasal cannula revealed it nasal canula and oxygen was uncovered and lying on the floor under the bed. tubing. On 10/03/18 at 8:30 a.m., an observation of 4. How does the facility Resident # 41's oxygen concentrator revealed the plan to monitor it's oxygen tubing and nasal were removed from performance to make Resident # 41's room. sure that the solutions The POS (physician order sheet) for Resident # are sustained? 41 dated October 2018 documented, "Oxygen 2 DON and/or Designee (two) liters/ (per) minute via (by) nasal cannula or will monitor nasal canula 11/16/2018 mask, PRN (as needed). Start Date: 09/21/2018." and oxygen tubing to

On 10/03/18 at 9:13 a.m., an interview was

conducted with LPN (licensed practical nurse) #

1. When asked to describe the procedure for the storage of a nasal cannula and oxygen tubing

when not in use, LPN #1 stated, "Keep it in a zip

informed of the observations of Resident # 41's

lock bag on the oxygen concentrator." When

oxygen tubing and nasal cannula lying on the floor under Resident # 41's bed, LPN # 1 stated she was not aware of it and that it should not

minutes.

ensure sanitary storage

DON will report results to

Findings and results will

be reflected in the QA

weekly x 3 weeks.

the QA committee.

11/16/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		49E075	B. WING		10	/04/2018	
	PROVIDER OR SUPPLIER TERRACE CONV HO	DME		STREET ADDRESS, CITY, STATE, ZIP CO PO BOX 558 WOODSTOCK, VA 22664			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 695	have stored like that The facility's policy Respiratory Equipm staff should ensure is bagged and store use. Bags containing supplies should be to maintain adequate On 10/093/18 at applies should be to maintain adequate On 10/093/18 at applies should be to maintain adequate On 10/093/18 at applies should be to maintain adequate On 10/093/18 at applies to maintain strative staff administrator and A were made aware of No further information. References: (1) There are many disease. The most of disease is narrowing arteries, the blood of the heart itself. This disease and happer major reason people kinds of heart proble in the heart, or the heart disease. This from the website: https://medlineplus.ic/	"Infection Control - nent" documented, "Facility that respiratory related tubing ed appropriately when not in ng respiratory equipment dated and placed in a location te infection control." proximately 5:00 p.m., ASM member) # 1, the SM # 2, director of nursing	F 6	RECEIV OCT 2 4 20 VDH/OL	118		
	(3) A nervous system	n disease that affects your					

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/11/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES **FORM APPROVED** STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 49E075 B. WING NAME OF PROVIDER OR SUPPLIER 10/04/2018 STREET ADDRESS, CITY, STATE, ZIP CODE SKYLINE TERRACE CONV HOME **PO BOX 558** WOODSTOCK, VA 22664 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PRÉFIX (X5) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG COMPLETION DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 695 Continued From page 42 F 695 brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. They can include visual disturbances, muscle weakness, F756 trouble with coordination and balance, sensations such as numbness, prickling, or "pins and 1. How will corrective needles" and thinking and memory problems. action be accomplished This information was obtained from the website: for those residents https://medlineplus.gov/multiplesclerosis.html. found to be affected by (4) High blood pressure. This information was the deficient practice? obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpr Monthly drug regimen essure.html. 11/16/2018 reviews have been F 756 Drug Regimen Review, Report Irregular, Act On F 756 completed by the CFR(s): 483.45(c)(1)(2)(4)(5) SS=E Physician for Resident's §483.45(c) Drug Regimen Review. #67, #25, #5, #13, and #4 §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a 2. How will the facility licensed pharmacist. identify other residents having the potential to §483.45(c)(2) This review must include a review be affected by the same of the resident's medical chart. deficient practice? §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the DON/ Designee will audit facility's medical director and director of nursing. monthly regimen reviews 11/16/2d18 and these reports must be acted upon. made within the last 30

(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph

(d) of this section for an unnecessary drug.

(ii) Any irregularities noted by the pharmacist

during this review must be documented on a

attending physician and the facility's medical

separate, written report that is sent to the

days to ensure that

been addressed by

recommendations have

pharmacy

Physician.

_CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FORM): 10/11/2018 1APPROVED
STALEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	OMB NO (X3) DAT	. 0938-0391 E SURVEY MPLETED
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		04/2018
SKYLIN	E TERRACE CONV HO			PO BOX 558 WOODSTOCK, VA 22664	_	
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	director and director minimum, the reside and the irregularity the seed and the irregularity the seed and the irregularity has been action has been taked be no change in the physician should dook the resident's medical \$483.45(c)(5) The farmaintain policies and drug regimen review limited to, time frame the process and step when he or she ident requires urgent action. This REQUIREMENT by: Based on observation document review, it was facility staff failed to diregimen review policy to address recommer pharmacist to the phy residents #67, #25, #8. For Resident #67, ensure the Monthly Respecified time frames to act upon any pharmacist upon	of nursing and lists, at a ent's name, the relevant drug, he pharmacist identified. A sysician must document in the ecord that the identified reviewed and what, if any, en to address it. If there is to medication, the attending nument his or her rationale in all record. Cility must develop and a procedures for the monthly that include, but are not as for the different steps in the pharmacist must take if it is not met as evidenced and the protect the resident. It is not met as evidenced and that included time frames and that the develop and that the develop and that the develop and that the develop and that the develop and the transfer a	F7		11/16/2	

DEPA	RTMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			PRINTE	D: 10/11/2018 APPROVED
STALEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	OMB NO (X3) DA	D. 0938-0391 TE SURVEY MPLETED
NAME OF	PROVIDER OR SUPPLIER	49E075	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	10	/04/2018
SKYLIN	E TERRACE CONV HO	DME		PO BOX 558 WOODSTOCK, VA 22664		ĺ
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	ensure the Monthly specified time frame to act upon any phare. 4. For Resident #13, ensure the Monthly I specified time frame to act upon any phare. 5. The facility staff faimplement policies the frames of the steps of review to guide staff irregularities reported. Resident #4. The findings include: 1. The facility staff faimplement policies the frames of the steps of review to guide staff of irregularities reported. Resident #67. Resident #67 was add 9/29/17 with the diagrous seizures, depression, degeneration, osteoald degeneration, neuropediction.	Regimen Review policy is in which the physician was reacy recommendations. The facility staff failed to Regimen Review policy in which the physician was reacy recommendations. The facility staff failed to Regimen Review policy in which the physician was reacy recommendations. The facility staff failed to Regimen and addressed the time of the medication regimen on the process for acting on the pharmacist for the medication regimen on the process for acting on by the pharmacist for the medication regimen on the process for acting on by the pharmacist for mitted to the facility on thoses of but not limited to anxiety, macular rethritis, intervertebral disceptible, and Alzheimer's	F 75			/12/2018
	disease. The most re Set) was an annual as (Assessment Referen resident was coded as impaired in ability to m	scent MDS (Minimum Data ssessment with an ARD sce Date) of 9/23/18. The s severely cognitively nake daily life decisions. ed as requiring total care for of daily living and as		RECEIVEL OCT 24 2018 VDH/OLC		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		49E075	B. WING			10/	04/2018
	PROVIDER OR SUPPLIER TERRACE CONV HO	OME		STREET ADDRESS, CITY, STATE, 2 PO BOX 558 WOODSTOCK, VA 22664	ZIP CODE		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 756	"Consultant Pharm Review" form for ea January through Se recommendations is medication regimen. A review of the faci Services" documer residents of (facility appropriate medications. Proced contract pharmacy effective medication reside in the facility basis. *The pharm residents and famil appropriate pharmacy effective medication reside in the facility basis. *The pharm residents and famil appropriate pharma supports the reside *Pharmaceutical selimited to acquiring administering, dispendications. *A phavailable with a selehand for emergence medication not bein communicate with the determine if an alter Licensed nursing selindicated. *Pharmamedication regimer indicated, to try to resident in the process of the proce	ical record revealed the acist's Medication Regimen ach month of 2018 from eptember. There were no made to the resident's	F 7	56			
	adverse reactions. irregularities will be	*Recommendations and reported to the facility staff					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		49E075	B. WING			10/	04/2018	
	PROVIDER OR SUPPLIER E TERRACE CONV HO	DME		РО	REET ADDRESS, CITY, STATE, ZIP CODE BOX 558 DODSTOCK, VA 22664			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 756	residents in a readil staff will monitor resmed to med interact condition to the phy. The policy did not swhich the physician recommendations. On 10/3/18 at 12:53 DON (director of nustaff member] #1, spharmacist and he the expectation is the expectation is the expectation is the expectation is the mext time he is in to look at them on a wate to make sure we geplaced in the MD (nlook at them. It does at it and made a reddoes not state any to the finding provided by the end. 2. For Resident #25 ensure the Monthly specified time frame to act upon any phase. Resident #25 was a second to the provided that the month of the finding provided the end.	of pharmacist reviews for all ly available location. *Facility sidents for side effects and tions and report any change in sician as indicated." pecify any time frames in must address any pharmacy B p.m., in an interview with the trsing), ASM [administrative he stated, "I spoke to the stated that if it was non urgent the physician reviews them the see the patient. Our doctors reekly basis and we follow up the replied back. They are nedical doctor) folder until they as not get filed until they look commendation. The policy time frames." p.m., the ASM #1 and ASM #2 if Members - the Administrator using, respectively) were made us. No further information was	F 7	56				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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F 756	Alzheimer's disease (Minimum Data Set with an ARD (Asset 8/19/18. The reside impaired in ability to The resident was cobathing and toileting dressing, and hygie was incontinent of the Areview of the clini "Consultant Pharms Review" form for ear January through Set was made on 4/24/regimen. The recoby the physician on recommendation where the compact of the Celecoxib (In and to consider a more than the Celecoxib. The [2] 20 mg daily on 4 Areview of the facil Services" document residents of (facility appropriate medical dosage, to promote limit adverse reactic conditions. Proced contract pharmacy effective medication reside in the facility basis. *The pharms residents and familia appropriate pharmacy appropriate pharmacy effective medication residents and familia appropriate pharmacy effective medication residents and fa	attention deficit disorder, and e. The most recent MDS t) was a quarterly assessment assment Reference Date) of ent was coded as being mildly of make daily life decisions. The odd as requiring total care for g; extensive care for transfers, ene; supervision for eating; and bowel and bladder. Ical record revealed the acist's Medication Regimen ach month of 2018 from extensive. A recommendation 18 to the resident's medication mmendation was addressed 4/25/18. The as regarding the resident's 1200 mg (milligrams) daily, nedication to reduce the risk of r bleed related to the use of ephysician ordered Protonix	F 7	756				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 756	limited to acquiring administering, disp medications. *A phavailable with a sell hand for emergence medication not being communicate with determine if an alter Licensed nursing stindicated. *Pharma medication regiment indicated, to try to may be caused by adverse reactions. irregularities will be and will be docume will maintain record residents in a readistaff will monitor residents. On 10/3/18 at 12:50 DON (director of nutstaff member] #1, spharmacist and he the expectation is the control of the physician recommendations.	ervices to include, but not be receiving, dispensing, osing, labeling and storing parmacy stat box will be ect list of medication to be only use. *In the event of a regardiable, the facility will the pharmacy and physician to remative may be ordered. The facility exists will receive orders as a recist will review each resident's at least monthly, and as minimize adverse effects that medication therapy and *Recommendations and reported to the facility staff and as indicated. *The facility of pharmacist reviews for all ly available location. *Facility sidents for side effects and stions and report any change in resician as indicated." The pecify any time frames in must address any pharmacy B. p.m., in an interview with the stated, "I spoke to the stated that if it was non urgent the physician reviews them the see the patient. Our doctors reckly basis and we follow up at replied back. They are medical doctor) folder until they look commendation. The policy	F 756	RECEIVEL OCT 2 4 2018 VDH/OLC			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED		
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F 756	(Administrative Sta and Director of Nur aware of the finding provided by the end [1] Celecoxib - "is tenderness, swelling osteoarthritis" Information obtained https://medlineplustml [2] Protonix - "is gastroesophageal recondition in which is stomach causes he the esophagusis GERD, allow the est further damage to to treat conditions we too much acid" Information obtained	p.m., the ASM #1 and ASM #2 ff Members - the Administrator sing, respectively) were made gs. No further information was d of the survey. s used to relieve pain, g and stiffness caused by d from gov/druginfo/meds/a699022.h used to treat reflux disease (GERD), a packward flow of acid from the earthurn and possible injury of used to treat the symptoms of sophagus to heal, and prevent the esophagus. It is also used where the stomach produces	F7	756	*1			
	ensure the Monthly specified time fram to act upon any pha Resident #5 was ac 6/25/18 with the dia epilepsy, cerebrova disease, Alzheimer	, the facility staff failed to Regimen Review policy es in which the physician was armacy recommendations. Imitted to the facility on agnoses of but not limited to scular disease, stroke, kidney is disease, neurogenic dementia, and deep vein						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING				(X3) DATE SURVEY COMPLETED	
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F 756	Data Set) was a que ARD (Assessment The resident was compaired in making resident was coded bathing; extensive eating, toileting, and of bowel and bladd. A review of the clini "Consultant Pharms Review" form for ead January through Serecommendations is medication regimer. A review of the facility appropriate medication regimer. A review of the facility appropriate medication facility appropriate medications. Proced contract pharmacy effective medication reside in the facility basis. *The pharms residents and familiappropriate pharmac supports the reside *Pharmaceutical selimited to acquiring, administering, dispendications. *A phavailable with a selehand for emergency medication not being medication not being the selection of the selection o	arterly assessment with an Reference Date) of 7/13/18. The last requiring total care for care for transfers, dressing, d hygiene; and was incontinent er. cal record revealed the acist's Medication Regimen ach month of 2018 from eptember. There were no made to the resident's	F 7	56			

F 756 Continued From page 51 determine if an alternative may be ordered. Licensed nursing staff will receive orders as indicated. *Pharmacist will review each resident's medication regimen at least monthly, and as indicated, to try to minimize adverse effects that may be caused by medication therapy and adverse reactions. *Recommendations and irregularities will be reported to the facility will maintain record of pharmacist reviews for all residents in a readily available location. *Facility staff will monitor residents for side effects and med to med interactions and report any change in condition to the physician as indicated.* The policy did not specify any time frames in which the physician must address any pharmacy recommendations. On 10/3/18 at 12:53 p.m., in an interview with the DON (director of nursing), ASM [administrative staff member] #1, she stated, "I spoke to the pharmacist and he stated that if it was non urgent		ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 756 Continued From page 51 determine if an alternative may be ordered. Licensed nursing staff will receive orders as indicated. "Pharmacist will review each resident's medication regimen at least monthly, and as indicated swill be documented as indicated. "The facility will maintain record of pharmacist reviews for all residents in a readily available location. "Facility staff will monitor residents for side effects and med to med interactions and report any change in condition to the physician must address any pharmacy recommendations. On 10/3/18 at 12:53 p.m., in an interview with the DON (director of nursing), ASM [administrative staff member] #1, she stated, "I spoke to the pharmacist and he stated that if it was non urgent					PO BOX 558		70-7/2010	
determine if an alternative may be ordered. Licensed nursing staff will receive orders as indicated. "Pharmacist will review each resident's medication regimen at least monthly, and as indicated, to try to minimize adverse effects that may be caused by medication therapy and adverse reactions. "Recommendations and irregularities will be reported to the facility staff and will be documented as indicated. "The facility will maintain record of pharmacist reviews for all residents in a readily available location. "Facility staff will monitor residents for side effects and med to med interactions and report any change in condition to the physician as indicated." The policy did not specify any time frames in which the physician must address any pharmacy recommendations. On 10/3/18 at 12:53 p.m., in an interview with the DON (director of nursing), ASM [administrative staff member] #1, she stated, "I spoke to the pharmacist and he stated that if it was non urgent	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	IOULD BE	COMPLETION	
next time he is in to see the patient. Our doctors look at them on a weekly basis and we follow up to make sure we get replied back. They are placed in the MD (medical doctor) folder until they look at them. It does not get filed until they look at it and made a recommendation. The policy does not state any time frames." On 10/3/18 at 5:12 p.m., the ASM #1 and ASM #2 (Administrative Staff Members - the Administrator and Director of Nursing, respectively) were made aware of the findings. No further information was provided by the end of the survey. RECEIVED OCT 24 2018 VDH/OLC	F 756	determine if an alte Licensed nursing stindicated. *Pharma medication regimer indicated, to try to may be caused by radverse reactions. irregularities will be and will be docume will maintain record residents in a readil staff will monitor resmed to med interaccondition to the phy The policy did not swhich the physician recommendations. On 10/3/18 at 12:53 DON (director of nustaff member] #1, spharmacist and he sthe expectation is the expectation in the MD (mok at them. It does at it and made a red does not state any the expectation of Nursaware of the finding	rnative may be ordered. aff will receive orders as a cist will review each resident's at least monthly, and as minimize adverse effects that medication therapy and *Recommendations and reported to the facility staff and as indicated. *The facility of pharmacist reviews for all y available location. *Facility sidents for side effects and tions and report any change in sician as indicated." pecify any time frames in must address any pharmacy a p.m., in an interview with the rsing), ASM [administrative he stated, "I spoke to the stated that if it was non urgent ne physician reviews them the see the patient. Our doctors eekly basis and we follow up at replied back. They are nedical doctor) folder until they are nedical doctor) folder until they are nedical doctor) folder until they are nedical doctor). The policy ime frames." b.m., the ASM #1 and ASM #2 if Members - the Administrator using, respectively) were made is. No further information was	F 7	RECEIV OCT 24 2	018		

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		49E075	B. WING		10	/04/2018	
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F 756	4. For Resident # ensure the Month specified time frait to act upon any place Resident #13 was 12/10/15 with the dementia, psychological blood pressure hernia, hepatitis Efibrillation, and Parecent MDS (Miniassessment with Reference Date) coded as being make daily life decoded as requiring extensive care for and hygiene; limit was incontinent of A review of the cli "Consultant Pharm Review" form for January through Strecommendation tapering the Clozal every morning and	range 52 13, the facility staff failed to by Regimen Review policy mes in which the physician was narmacy recommendations. admitted to the facility on diagnoses of but not limited to sis, depression, hallucinations, re, osteoporosis, anxiety, deep vein thrombosis, atrial rkinson's disease. The most mum Data Set) was an annual an ARD (Assessment of 7/21/18. The resident was oderately impaired in ability to cisions. The resident was go total care for bathing; transfers, dressing, toileting, ed assistance for eating; and bowel and bladder. Inical record revealed the macist's Medication Regimen each month of 2018 from September. There was a dated 9/20/18 for considering upine [1] 12.5 mg (milligram) d 25 mg every night. As of the been signed by the physician	F 7		:NCY)		
	A reviewed and a A review of the fact Services" docume residents of (facili appropriate medic dosage, to promo- limit adverse reac						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 756	contract pharmacy effective medication reside in the facility basis. *The pharm residents and fami appropriate pharmacutical selimited to acquiring administering, disp medications. *A phavailable with a sel hand for emergence medication not being communicate with determine if an alternation regiment indicated. *Pharmamedication regiment indicated, to try to may be caused by adverse reactions. irregularities will be and will be document will maintain record residents in a readistaff will monitor remed to med interaction to the physician recommendations.	services to promote safe and n usage for the residents who of on a regular and emergency facist will work with facility staff, lies and physicians to ensure accutical services, which ents' needs, are met. ervices to include, but not be not receiving, dispensing, osing, labeling and storing farmacy stat box will be ect list of medication to be oney use. *In the event of a farmacy and physician to ernative may be ordered. It is will review each resident's facility will receive orders as acist will review each resident's facility at least monthly, and as minimize adverse effects that medication therapy and areported to the facility staff ented as indicated. *The facility of pharmacist reviews for all ally available location. *Facility sidents for side effects and etions and report any change in visician as indicated." Specify any time frames in must address any pharmacy	F 75	56		
	DON (director of no staff member] #1, s pharmacist and he	ursing), ASM [administrative she stated, "I spoke to the stated that if it was non urgent he physician reviews them the		2		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING				(X3) DATE SURVEY COMPLETED		
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F 756	next time he is in to look at them on a sto make sure we go placed in the MD (look at them. It do at it and made a redoes not state any On 10/3/18 at 5:12 (Administrative Stand Director of Nu aware of the finding provided by the entitle of the motions) in patient by other medication themselves and arthemselves and arthemselves again. medications called works by changing substances in the Information obtain https://medlineplustml 5. The facility staff implement policies frames of the steps review to guide stairregularities report Resident #4. Resident #4 was a	o see the patient. Our doctors weekly basis and we follow up get replied back. They are medical doctor) folder until they be not get filed until they look ecommendation. The policy time frames." 2 p.m., the ASM #1 and ASM #2 aff Members - the Administrator rsing, respectively) were made gs. No further information was d of the survey. 2 papine is used to treat the cophrenia (a mental illness that or unusual thinking, loss of strong or inappropriate and the survey of the survey of the survey of the survey of the survey. 2 papine is used to treat the cophrenia (a mental illness that or unusual thinking, loss of strong or inappropriate and the survey of	F 7	56				

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were rinfection most rassess date) of severe resident for Aprice review any irreview any irresident appropriate fection resident resident appropriate fection resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resi	on and high of ecent MDS (sment with an of 7/9/18, cool of 7/9/18, cool of 7/9/18, cool of 7/9/18, cool of 7/9/18, cool of 7/9/18, cool of 7/9/18, cool of 7/9/18, cool of Resident 2018 through a document of the facility of the steps of the steps of the steps of the steps of the facility or and familiarity of the facility of the faci	anxiety disorder, urinary tract cholesterol. Resident #4's minimum data set), a quarterly ARD (assessment reference led the resident's cognition as #4's clinical record revealed medication regimen reviews gh September 2018. The ed no new irregularities. It is staff failed to develop and that addressed the time of the medication regimen for the process for acting on ported by the pharmacist. If y policy, "Pharmacy ted, "Purpose: To ensure the ensure the ensure the ensure the ensure the ensure the ensure treating medical tons, at the therapeutic ensure the	F 7	756	RECEIVED OCT 2 4 2018 VDH/OLC		

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F 756	determine if an alte Licensed nursing stindicated. *Pharma medication regimer indicated, to try to nay be caused by adverse reactions. irregularities will be and will be docume will maintain record residents in a readil staff will monitor resmed to med interaccondition to the phy On 10/3/18 at 12:53 ASM (administrative director of nursing), pharmacist and heat the expectation is the expectation is the expectation is the expectation is the expectation in the look at them on a wear to make sure we geplaced in the MD (molook at them. It does at it and made a record does not state any the control of the expectation is the sure we geplaced in the MD (molook at them. It does at it and made a record of the expectation is the expectation is the expectation in the MD (molook at them. It does at it and made a record of the expectation is the expectation in the MD (molook at them. It does at it and made a record of the expectation is the expectation in the expectation is the expectation in the expectation in the expectation is the expectation in the expectation in the expectation is the expectation in the expectation in the expectation is the expectation in the ex	rnative may be ordered. aff will receive orders as acist will review each resident's at least monthly, and as aninimize adverse effects that medication therapy and *Recommendations and reported to the facility staff anted as indicated. *The facility of pharmacist reviews for all y available location. *Facility sidents for side effects and tions and report any change in sician as indicated." 8 p.m., in an interview with e staff member) #2 (the she stated, "I spoke to the stated that if it was non urgent are physician reviews them the see the patient. Our doctors eekly basis and we follow up at replied back. They are medical doctor) folder until they as not get filed until they look commendation. The policy ime frames."	F 7	56			
F 880 SS=D	Infection Prevention CFR(s): 483.80(a)(1 §483.80 Infection C	1)(2)(4)(e)(f)	F 88	OCT 24 2018 VDH/OLO	ס		

STREMENT OF DEFICIENCIES AND PLAN OF CORRECTION AND PLAN OF CORRECTION AND PLAN OF CORRECTION AND PLAN OF CORRECTION AND PLAN OF CORRECTION AND PLAN OF CORRECTION AND PLAN OF CORRECTION AND PLAN OF CORRECTION AND PLAN OF CORRECTION AND PLAN OF CORRECTION AND PLAN OF CORRECTION AND PLAN OF CORRECTION AND PROVIDER OR SUPPLIER SKYLINE TERRACE CONV HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) FREGULATORY OR LSC IDENTIFYING INFORMATION) F 880 Continued From page 57 infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. \$483.80(a) (infection prevention and control program (IPCP) that must include, at a minimum, the following elements: \$483.80(a) (infection prevention and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to \$483.70(e) and following accepted national standards; \$483.80(a)(2) Writen standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility. (ii) When and to whom possible incidents of communicable disease or infections should be reported; INFORMATION ARCHITECTURE (APPROPRIATE TO THE SHOULD BE DOME TO THE SHOULD BE CROSS-REFERENCED TO THE SHOULD BE CROSS-REFERENCED TO THE SHOULD BE CROSS-REFERENCED TO THE SHOULD BE CROSS-REFERENCED TO THE SHOULD BE CROSS-REFERENCED TO THE SHOULD BE CROSS-REFERENCED TO THE SHOULD BE CROSS-REFERENCED TO THE SHOULD BE CROSS-REFERENCED TO THE SHOULD BE CROSS-REFERENCED TO THE SHOULD BE CROSS-REFERENCED TO THE SHOULD BE CROSS-REFERENCED TO THE SHOULD BE CROSS-REFERENCED TO THE	DELYL	MINIEWI OF HEALTH	AND HUMAN SERVICES			PRINTE	ED: 10/11/20	110
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SKYLINE TERRACE CONV HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUILATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROPUNDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUILATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROPUNDERS PLAN OF CORRECTION (EACH CORRECTOR ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY)	1141-2		49E075	B. WING	i	1		
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F880 Continued From page 57 infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. \$483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program. The facility must establish an infection prevention and control program. (IPCP) that must include, at a minimum, the following elements: \$483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to \$483.70(e) and following accepted national standards; \$483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections should be reported; iii) When and to whom possible incidents of communicable disease or infections should be reported;	(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	1 15				ı
infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of system for preventing, identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;		! (CAUR DEFICIENCY	MIIST RE DOCCEDED DV CIII.	PREFI	CROSS-REFERENCED TO THE APPRO	אסכ	COMPLETIO	N
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and		infection prevention designed to provide comfortable environal development and tradiseases and infection program. The facility must estate and control program a minimum, the following services unarrangement based usually conducted according accepted national state \$483.80(a)(1) A system of surveil providing services unarrangement based usually conducted according accepted national state \$483.80(a)(2) Written procedures for the probut are not limited to: (i) A system of surveil procedures for the probut are not limited to: (ii) A system of surveil procedures for the probut are not limited to: (ii) When and to whom communicable disease reported; (iii) When and to whom communicable disease reported; (iii) Standard and transo be followed to preventive when and how iso resident; including but A) The type and dural depending upon the index of the province of the procession of the procession of the facility; (iii) Standard and transo be followed to preventive and dural depending upon the index of the province and dural depending upon the index of the province and dural depending upon the index of the province and dural depending upon the index of the province and the province a	and control program a safe, sanitary and ment and to help prevent the ansmission of communicable ons. prevention and control ablish an infection prevention (IPCP) that must include, at wing elements: em for preventing, identifying, ng, and controlling infections iseases for all residents, fors, and other individuals ader a contractual upon the facility assessment to §483.70(e) and following andards; a standards, policies, and ogram, which must include, lance designed to identify ple diseases or can spread to other m possible incidents of the or infections should be smission-based precautions ent spread of infections; lation should be used for a not limited to: tion of the isolation	F8	F880 1. How will corrective action be accomplished for those residents found to be affected by the deficient practice? DON and/or designee provided treatment following proper infection control practices for Resident #34. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? DON and/or designee will observe the care of residents with current orders for treatments to ensure infection control practices are followed during the administration			

DEFAULTIMENT OF HEALTH AND HUMAN SERVICES

_CENT	ERS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			Р	RINTEI FORM	D: 10/11/2018 MAPPROVED
I STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DA). 0938-0391 TE SURVEY MPLETED
		49E075	B. WING	3			4
NAMEO	PROVIDER OR SUPPLIER			T	STREET ADDRESS, CITY, STATE, ZIP CODE	10	/04/2018
SKYLI	IE TERRACE CONV HO	DME			PO BOX 558 WOODSTOCK, VA 22664		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID				
PREFIX TAG	REGULATORY OR LS	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	DE	(X5) COMPLETION DATE
F 880	Continued From pag	ne 58		200			
		nat the isolation should be the	ГС	880	'		!
	circumstances.	sible for the resident under the					
	(v) The circumstanc	es under which the facility			3. What measures will		1
	Inust pronibit emplor	yees with a communicable skin lesions from direct			be put into place or		
	contact with resident	ts or their food, if direct			systemic changes made		1
	contact will transmit	the disease: and			to ensure the deficient]
	(vi)The hand hygiene	procedures to be followed			practice will not		
	by stall involved in d	irect resident contact.			reoccur?		
	§483.80(a)(4) A systidentified under the f	em for recording incidents acility's IPCP and the			DON and/or designee will		
	corrective actions tal	cen by the facility.			educate licensed nursing	11/16	/2018
					staff on the infection	1	
	§483.80(e) Linens.	dle, store, process, and			control practice of		
	transport linens so as	s to prevent the spread of			placing a clean barrier		
	infection.	to prevent the spread of			between the bed and the		
	§483.80(f) Annual re	4			resident, while		
	The facility will condu	ct an annual review of its		ľ	administering a		2
	IPCP and update the	ir program, as necessary			treatment.		İ
	THIS DEGOLATIONEN	is not met as evidenced					1
	by:	n stoff intended (
	document review, and	n, staff interview, facility d clinical record review it					Į.
	was determined that i	the facility staff failed to		İ			2
	tollow intection contro	practices for one of 24					į.
	residents in the surve	y sample, Resident # 34.					
	The facility staff failed	to follow infection control					
	practices while admin	istering a treatment to					
	Resident # 34. During	a wound care observation					59
]	a clean barrier on the	al nurse) # 1 failed to place bed under Resident # 34's					
ļ	right foot while cleans	ing a vascular wound.					
ļ							
1							

CENT	THE FOR MEDICADE	AND HUMAN SERVICES			PRINTED: 10/11/2018
STATEME	AT OF DEFICIENCES	& MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		49E075	B. WING		(3)
NAME O	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	10/04/2018
SKYLIN	IE TERRACE CONV HO	ME		PO BOX 558	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		WOODSTOCK, VA 22664	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	The state of the property of t	ILD BE COMPLETION
	Continued From page The findings included Resident # 34 was a 05/23/17 with diagnor not limited to: gastro (1), gout (2), peripher hypertension (4). Resident # 34's mosset), an annual asset (assessment referent Resident # 34 as socianterview for mental service for making daily decicoded as requiring lir of one staff member. On 10/03/18 at 9:35 at (licensed practical nut # 34's wound care was entering Resident # 34' Resident # 34 of what regarding his wound a content of the conten	de 59 de control de de control d	F 8	DEFICIENCY)	11/16/2018 11/16/2018
	wound. LPN # 1 told I use some saline to loo not pull on the wound. plastic bottle of saline,	Resident # 34 she would psen the dressing so it did LPN # 1 then opened a poured some over the sening the gauze. LPN # 1			

SEL ALTIVIENT OF REALTH AND HUMAN SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/11/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES **FORM APPROVED** STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 49E075 B. WING NAME OF PROVIDER OR SUPPLIER 10/04/2018 STREET ADDRESS, CITY, STATE, ZIP CODE SKYLINE TERRACE CONV HOME **PO BOX 558** WOODSTOCK, VA 22664 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG COMPLETION DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 880 Continued From page 60 F 880 then removed the dressing from Resident # 34's number one toe on the right foot. Further observation of LPN # 1 procedure of applying the saline to loosen the gauze revealed that excess saline from the wound on the toe flowed down Resident # 34's right foot and dripped onto the bed sheet. After removing the old dressing LPN # 1 washed her hands, donned a clean pair of disposable gloves, placed a clean pad under Resident # 34's right foot, cleaned the wound with saline, removed her gloves, washed her hands and donned a clean pair of disposable gloves, applied santyl (5) and a clean dressing. On 01/03/18 at 11:55 a.m., an interview was conducted with LPN # 1. When asked to describe the process they follow for infection control during wound care, LPN # 1 stated, "Wash hands, remove old dressing, wash hands again, clean the wound, apply the dressing according to the physician's orders, wash hands, and remove all soiled items from the trash can." When asked about providing a clean barrier, LPN # 1 stated, "I would place a barrier under the body part or dressing." When informed of the observation of the saline dripping onto Resident # 34's bed, LPN # 1 stated, I should have put a barrier down under his feet when I started." The facility's policy "Wound Care" documented, "Apply appropriate barriers to location of treatment as indicated." On 10/093/18 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the VDH/OLC administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

PRINTED: 10/11/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 49E075 B. WING 10/04/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **PO BOX 558** SKYLINE TERRACE CONV HOME WOODSTOCK, VA 22664 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 880 l Continued From page 61 F 880 References: (1) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (2) A type of arthritis. It occurs when uric acid builds up in blood and causes inflammation in the ioints. This information was obtained from the website: https://medlineplus.gov/ency/article/000422.htm. (3) The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog

vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was

https://www.nlm.nih.gov/medlineplus/vasculardise

(4) High blood pressure. This information was

https://www.nlm.nih.gov/medlineplus/highbloodpr

(5) An FDA-approved prescription medicine that removes dead tissue from wounds so they can start to heal. Proper wound care management is important to help remove nonliving tissue from

your wound properly. This information was obtained from the website: https://santyl.com/

obtained from the website:

obtained from the website:

ases.html.

essure.html.