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

PRINTED: 03/17/2021 FORM APPROVED OMB NO: 0938-0391

	OF DEFICIENCIES F CORRECTION	Live investigation [[Min Mark Min M			(X3) DATE SURVEY COMPLETED		
		495226	B. WING			03/	12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAE	ILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947				
(X4) ID PREFIX TAG	(ÉACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 000	An unannounced Em survey was conducte Corrections are requi CFR Part 483.73, Re Care Facilities. EP Training Program	nergency Preparedness d 3/9/21 through 3/12/21. red for compliance with 42 quirement for Long-Term		000	Wayland Nursing and Rehabilitation of acknowledges receipt of the Statemer Deficiencies and proposes this Plan of Correction to the extent that the summifindings is factually correct and in order maintain compliance with the applicabilities and provisions of quality of care residents. This Plan of Correction is submitted as a written allegation of	nt of f nary of er to ble	
SS= <u>D</u>	EO37 EP Training Program CFR(s): 483.73(d)(1) *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training				compliance. Wayland Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Wayland Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedur and/or any other administrative or legal proceeding.		
	preparedness training (iv) Demonstrate emergency procedure (v) If the emerger and procedures are s [facility] must conduct policies and procedur *[For Hospices at §41 hospice must do all of (i) Initial training if policies and procedur hospice employees, a	Maintain documentation of all emergency dness training. Demonstrate staff knowledge of ncy procedures. If the emergency preparedness policies cedures are significantly updated, the must conduct training on the updated and procedures. Despices at §418.113(d):] (1) Training. The must do all of the following: nitial training in emergency preparedness and procedures to all new and existing employees, and individuals providing a under arrangement, consistent with their deroles. F 037 New Hires since June 2020 will receive training on Emergency preparednes by 3/29/21, the training will be completed by the Staff Development Coordinator. New hires have been identified and will receive training by 3/29/21 by the Staff Development Coordinator. The SDC will in-service all new hire from June 2020 on the Emergency Preparedness Plan as outlined in the Emergency Preparedness policy and procedure manual. All new hires will receive in-service training on Emergency Preparedness upon hire and annually thereafter.		Iness d by I and caff hires			
ABORATORY (NIXECTOR'S OR PROVIDER/S	UPPLIER REPRESENTATIVE'S SIGNATURE	!		\\ TITLE \		(X6) DATE

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

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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	B. WING			03/	12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		73	REET ADDRESS, CITY, STATE, ZIP CODE 0 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X9) CONPLETION DATE
E 037	emergency procedure (iii) Provide emer at least every 2 years (iv) Periodically re emergency preparedre employees (including special emphasis plan procedures necessary others. (v) Maintain docu- preparedness training (vi) If the emerge and procedures are si- hospice must conduct policies and procedure *[For PRTFs at §441. program. The PRTF in (i) Initial training if policies and procedure staff, individuals provi- arrangement, and voli- expected roles. (ii) After initial tra preparedness training (iii) Demonstrate emergency procedure (iv) Maintain docu- preparedness training (v) If the emerger and procedures are s PRTF must conduct to policies and procedure *[For LTC Facilities at	staff knowledge of as. gency preparedness training eview and rehearse its ness plan with hospice nonemployee—staff), with ced on carrying out the y to protect patients and imentation of all emergency incy preparedness policies ignificantly updated, the training on—the updated es. 184(d):] (1) Training nust do all of the following: n emergency preparedness es to all new and existing ding—services under unteers, consistent with their ining, provide emergency every 2 years. staff knowledge of its. umentation of all emergency incy preparedness policies ignificantly updated, the raining on—the updated	E. C.	37	Continued from page 1 Facility Administrator will revie new hire orientation process weekly x to assure EP training is performed & documented appropriately per the orienchecklist as outlined by the EP policy a procedure manual. All orientation new hire check be reviewed in monthly QAPI meetings month.	4 weeks ntation and lists will	04/12/21

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

	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495228	B. WING			03/	12/2021
	OF PROVIDER OR SUPPLIER LAND NURSING AND REHAI	BILITATION CENTER		STREET ADDRESS, CITY, STATE, 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	ZIP CODE	·	
(X4 PRI T,	FIX (EACH DEFICIENT	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED			(X5) COMPLETION DATE
E	policies and procedus staff, individuals procedured role. (ii) Provide emerat least annually. (iii) Maintain doc preparedness trainin (iv) Demonstrate emergency procedured reference at §485 CORF must do all of (i) Provide Initial preparedness policies and existing staff, increased emergency procedured reference at least every 2 years (iii) Provide emerat least every 2 years (iii) Provide emerat least every 2 years (iii) Demonstrate emergency procedured emergency procedured emergency procedured emergency plan with workday. The training instruction in the local systems and signals (v) If the emergency procedures are secons of the conduct policies and procedure are second reconduct policies and procedure the CAH must do all	in emergency preparedness res to all new and existing riding services under funteers, consistent with their gency preparedness training umentation of all emergency g. staff knowledge of es. 68(d):](1) Training. The the following: training in emergency s and procedures to all new ividuals providing gement, and volunteers, expected roles. gency preparedness training the umentation of the training. Staff knowledge of es. All new personnel must and specific egarding the CORF's in 2 weeks of their first program must include and firefighting equipment, ency preparedness policies ignificantly updated, the training on the updated es. 25(d):] (1) Training program.	E	037			

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

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495226	B. WING	Balvadi sahamarinah dahlalif dali darer urudukka udikh 4467-44 silaar i	٥	3/12/2021	
	ROVIDER OR SUPPLIER D NURSING AND REH	ABILITATION CENTER	73	REET ADDRESS, CITY, STATE, ZIP CODE 0 LUNENBURG HIGHW EYSVILLE, VA 23947		0.14.2021	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION: CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
E 037	reporting and exting and where necessary personnel, and gue cooperation with authorities, to all not individuals providing and volunteers roles. (ii) Provide emat least every 2 year (iii) Maintain do (iv) Demonstrate emergency procedures are CAH must conduct policies and procedures and provide preparedness policies and existing staff, funder arrangement with their expected documentation of the demonstrate staff k procedures. There emergency prepare years. This REQUIREMENT by: Based on staff intereview, it was deterfailed to have a conpreparedness plan provide documente facility hires since J	dures, including prompt guishing of fires, protection, any, evacuation of patients, asts, fire prevention, and firefighting and disaster aw and existing staff, g services under arrangement, c, consistent with their expected ergency preparedness training ars. commentation of the training atte staff knowledge of ares. rgency preparedness policles a significantly updated, the training on the updated ares. 85.920(d):] (1) Training. The es initial training in emergency ales and procedures to all new andividuals providing services and volunteers, consistent roles, and maintain the training. The CMHC must nowledge of emergency after, the CMHC must provide adness training at least every 2 NT is not met as evidenced rview and facility document mined that the facility staff	E 037				

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495228	B. WING		03	1/12/2021	
	PROVIDER OR SUPPLIER D NURSING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
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E 037	Continued From page	4	E	037			
	The findings include:						
	emergency preparedn This review of the fact preparedness plan fail documentation that the June 2020, have recei preparedness training	led to evidence a 20 new facility hires since ived initial emergency					
	staff member) #1, the director of nursing. As consultant, and ASM # vice-president, were in ASM #1 stated that the coordinator is respons emergency preparednessed development coordinates extended leave, and how hires had been to preparedness since shadown.	44, the regional aformed of these concerns a staff development ible for new hire training in ass. He stated the staff tor has been out on a could not verify that any					
	INITIAL COMMENTS An unannounced Med survey was conducted		FC	000			
	survey/report will follow	v. Pertified bed facility was 50					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	B. WING			03/	12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAB	LITATION CENTER		73	(REET ADDRESS, CITY, STATE, ZIP CODE 10 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
F 000 F 600 SS≖G	§483.12 Freedom from Exploitation The resident has the inneglect, misappropria and exploitation as delincludes but is not limicorporal punishment, any physical or chemitreat the resident's message of the facility \$483.12(a) The facility \$483.12(a) (1) Not use physical abuse, corporativoluntary seclusion; This REQUIREMENT by: Based on resident infacility document revisit was determined that one of 35 residents in resident-to-resident all #37 and Resident #4 escalated to Resident #4's right low Resident #4'	ent reviews. Neglect In Abuse, Neglect, and right to be free from abuse, tion of resident property, ifined in this subpart. This lited to freedom from involuntary seclusion and cal restraint not required to edical symptoms. In must- In verbal, mental, sexual, or rel punishment, or Is not met as evidenced erview, staff Interview, when and clinical record review It the facility failed to protect the survey sample from buse. On 2/28/21, Resident argued in their room which #37 pushing his wheelchair lie causing a laceration to wer leg that required mergency room and closure		600	Past noncompliance: no plan of correction required.		
	Resident #4 was adm	itted to the facility with ut not limited to chronic					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE 8 MEDICAID SERVICES

STATEMENT OF AND PLAN OF (F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495228	B. WING			03/	12/2021
	OVIDER OR SUPPLIER NURSING AND REHAB	LITATION CENTER		7:	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
i (i) (i) (i) (i) (i) (i) (i) (i) (i) (i	heart failure (2) and mail (3). Resident #4's modeta set), an annual a (assessment reference Resident #4 as scorin interview for mental stintact for making daily. On 3/9/21 at approximaterview was conducted Resident #4 was obseduesting dated 3/9/21 When asked about the eg. Resident #4 state their previous roommato go to the emergence of the close an injury. Resident #37 was not because "they got rid Resident #37 over the Resident #37 over the Resident #37 pushed through the privacy curber bed table to cut he stated that the nurshe area and he had to get staples to the and the getting a roommate to "2/28/2021 16:25 (4:27/2021 16	disease (1), congestive related depressive disorder strecent MDS (minimum assessment with an ARD e date) of 3/1/21 coded g a 15 on the BIMS (brief atus), 15- being cognitively decisions. Intelly 3:10 p.m., an ed with Resident #4. Inved to have a gauze wrap on his right lower leg. Is dressing on his right lower of that he was assaulted by ate, Resident #37 and had by room to get staples in his Resident #4 stated that longer in the facility of him after that happened." At he had ergued with at elevision and that his empty wheelchair ritain into him causing the alls right lower leg. Resident as had to apply pressure to a go to the emergency room rea. The Resident #4 documented 1:26 a.m.) Note Text: Writer advised that he would be	F	600			

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CALCIALITY	STORINEDICARE &	MEDICAID SERVICES		<u></u>	OMB NO 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	B. WING	grejog daladi dalikili daljem giriq garajem dengenovih, oya ili pamaggang gayaran, g	03/12/2021
NAME OF P	ROVIDER OR SUPPLIER	1	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
WAYLANI	NURSING AND REHAB	ILITATION CENTER	I '	LUNENBURG HIGHW SVILLE, VA 23947	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENT(FYING INFORMATION)	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 600	each other names, restand the way his rooway he "[curse] on his resident that he can resident that he can rewind without control of) his roommate & curse compromise with what "2/28/2021 16:40 (4 to room Resident notion (centimeter) lacer lower leg. Resident had his can, blood dripping in roommate pushed the other side of the curta which hit his leg. Roo removed from the roowound for several mir wrapped with gauze. needed to go to the Excessive bleading, & Resident still arguing, the room mate interm wanted to have "the course]" because "he made aware & stated to a room on C-wing to would straighten it our residents." - "2/28/2021 17:01 (5) Resident sustained rig (8.5 cm laceration) by RN [registered nurse] dressing. Received versing. Received versing.	sident states he cannot m mate talks to him & the mself". Writer explained to not help being incontinent awever, he should not yell at at him. They should try to at to watch on the TV." 40 p.m.) Note Text: called ad to be bleeding from a 8.5 ation on the right lateral olding tissues on wound, noted on the floor & In trash aleg propped on the trash to it. Resident stated that his aw/c (wheelchair) on the nin into his overbed table, mmates w/c [wheelchair] m, pressure applied to nutes to slow bleeding, Explained to resident that he R (emergency room) due to a for a tetanus shot. cursing & threatening with littently, yelling that he ops called on that plece of assaulted me" Administrator that resident needed to go upon return from ER & he in the morning with both 01 p.m.) Note Text: ght lower extremity trauma contact with wheelchair, supervisor applied pressure arbal order from [name of send resident to ER. Report	F 600		

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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	B. WING			1 03	/12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER	· · · · · · · · · · · · · · · · · · ·	730	REET ADDRESS, CITY, STATE, ZIP CODE D LUNENBURG HIGHW YSVILLE, VA 23947		1 1 34 1 56 1 24 5
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS:REFERENCED TO THE APPROPR DEFICIENCY)	BE.	(X5) COMPLETION DATE
F 600	- "2/28/2021 20:40 (8: Returned to facility affinew orders for Keffex (milligrams) q (every) Resident is own RR a - "3/1/2021 13:02 (1:0 stated that he wanted against roommate for staples in lower leg. T Name] Sheriff Dept. S several times. Also no ombudsman] LTC (for and [Name of staff] wiservices). Awaiting rei with [County Name]." - "3/1/2021 17:31 (5:3 Investigator and deputed the "ED (emergency Physician" for Reside Hospital) dated 2/28/2 "Chief complaint froi argument with roomminto each other; lacera dressing on with contrage and sex of Reside emergency department into each other; lacera dressing on with contrage and sex of Reside emergency department into each other; lacera dressing on with contrage and sex of Reside emergency department into each other; lacera dressing on with contrage and sex of Reside emergency department into each other; lacera dressing on with contrage and sex of Reside emergency department into each other; lacera dressing on with contrage and sex of Reside emergency department into each other; lacera dressing on with contrage and sex of Reside emergency department into each other; lacera dressing on with contrage and sex of Reside emergency department into each other; lacera dressing on with contrage and sex of Reside emergency department into each other; lacera dressing on with contrage and sex of Reside emergency department into each other; lacera dressing on with contrage and sex of Reside emergency department into each other; lacera dressing on with contrage and sex of Reside emergency department into each other; lacera dressing on with contrage and sex of Reside emergency department into each other; lacera dressing on with contrage and sex of Reside emergency department into each other; lacera dressing on with contrage and sex of Reside emergency department into each other; lacera dressing on with contrage and sex of Reside emergency department into each other; lacera dressing on with emergency and experiment into each other into each other into each other into each other	do a.m.) Note Text: er receiving 9 staples and (antibiotic) 500 mg 12 hours x 10 days. Indis aware." 2 p.m.) Note Text: Resident to file assault charges Injuring him causing 9 his writer notified [County poke with investigator diffied [Name of the APS (adult protective turn call from investigator ty in to speak with resident." department) Note in #4 from [Name of 021, documented in part, in [Name of facility] - verbal ate; knocked wheelchairs	E.	600			

CENTER	DENTERS FOR MEDICARE & MEDICAID SERVICES							
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	100	(X3) DATE S COMPL		
		495226	B. WNG _			03/1	2/2021	
	ROVIDER OF SUPPLIER NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, 730 LUNENBURG HIGH KEYSVILLE, VA 2394	w			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRI DEFIGIENCY)		(X5) COMPLETION DATE	
F 600	diagnoses including disease (4), major d anxiety disorder (5). MDS (minimum data with an ARD (assess 2/8/21 coded Reside BIMS (brief interview cognitively intact for Section E document evidence documents symptoms during the Resident #37 no lon could not be observed The record was revisible. The comprehensive dated 12/28/2020 do "Problematic manner characterized by ine physical Aggression related to: Anger, cuthreatening to hurt so 12/22/2020, Created 03/08/2021." The comprehensive feelings regulationships characterized to: displays of the comprehension with pate initiated: 01/04/2021, Revision 101/04/2021, Re	but not limited to Parkinson's epressive disorder and Resident #37's most recent a set), a quarterly assessment sment reference date) of ent #37 as scoring a 15 on the vice for mental status), 15-being making daily decisions, and Resident #37 failed to atton of any behavioral a observation period. Ger resided at the facility and adduring the survey dates, award as a closed record. Care plan for Resident #37 becomented in part, or in which resident acts affective coping; verball or Agitated, Combativeness in rsing, yelling at staff, taff. Date initiated: If on: 12/22/2020, Revision on: are plan further documented, agarding self and social terized by; low self esteem, inflict/anger, ineffective coping of inappropriate social elf to staff, inappropriate staff through letters & email. J.	F6	00				
	The progress notes in part the following:	for Resident #37 documented						
	- "12/20/2020 14:52	(2:52 p.m.) Note Text: CNA						
ORM CM6-256	37(02-99) Previous Versions O	bsolete Event ID: D6	7X11	Facility ID VA0050	If contin	uation sheel	Page 10 of 9	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MUL A BUILDI		STRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	O. VANG			03/	12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAB	LITATION CENTER		730 L.U	TADDRESS, CITY, STATE, ZIP CODE JNENBURG HIGHW IVILLE, VA 23947		
(X4) tO PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOUL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X4) COMPLETION DATE
F 600	stated that resident with that she set up a bed #37] to go ahead and face to his waist. She will be right back bedgoing off. About 10 might and he put his call light room and apologized back to him he started threatened to "Kick might stated he hopes that a also threatened to call it before. He also state feed himself so that Chim because he pays he want his moneys wanother CNA heard him with a money wand the collocal Care Coordinated Clinical Care Coordin	stant) came to writer and as cursing her. She stated bath, she asked (Resident get started washing his then informed him that she hase she had 2 call lights ins (minutes) had passed at on. When she went in the for taking longer to hat [sic] I cursing at her. She sald he y [curse words]". Then he she become paralyzed. He I the state and he has done at that he would refuse to NAs would have to feed good money to be here and forth. Housekeeper and moursing and yelling." 8:37 a.m.) Note Text: This is a Coordinator went in to staff reported that resident sing them, calling staff MF ening staff. This writer and after explained to resident coeptable and if continued harge. Explained that there municating with staff other cursing staff. Resident and report yall for abuse. I ated I will just walk to the yall." Resident stated that LTC (long-term care) ter provided resident with me of Ombudsman) LTC	F	600			

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

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		495226	8. WING		0:	3/12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAL	BILITATION CENTER		STREET ADDRESS, CITY, STATE, Z 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FUILL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE	TO THE APPROPRIATE	(X5) COMPLETION DATÉ
F 600	coordinator resident out of the bed pushe hallway. Very unsteat - "12/23/2020 12:06 writer and AR in to significant of his insurance will not care) stay. Resident father. Resident's significant can not return father. Stated that the stated that he is not	worker and clinical care became angry and got up d his bedside table into the	F	600		
	given note from CNA gave her. Note entai number and email no signed by resident. (her why she didn't co resident stating that was illegal. Resident comment. No further	(1:21 p.m.) Note Text: Was Iname of CNA] that resident is resident's personal phone of reads I missed you, CNA states resident asked all him, CNA responded to would be inappropriate and wasn't happy with her gestures at this time, CNA staff members should be for resident."				
	Received call from L that she received a v stating that he is not Explained to [Name Ombudsman) that re CNA with his person email address, cell p advised Clinical Care	(2:19 p.m.) Note Text: TC Ombudsman regarding voicemail from resident allowed to have friends here. of Ombudsman] (LTC sident was sending note to a al information on it such as whone number and that CNA be Coordinator. CNA stated to				

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Chald that	AD LECTION MILESTANTINE CO.	MEDICARD SEKAICES				TIME INC. DEPRIORE
	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		(X:I) DATE SURVEY COMPLETED
		495226	B. WING			03/12/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
WAYLAND	NURSING AND REHAB	ILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA	
F 600	Received fax from Ha [department of social apply for Medicaid. Reaccount and vehicle a wife's name. This writ Harrisonburg DSS at message to inquire he since the wife has a president." - "12/30/2020 12:18 ('asked this writer to spresident wanted CNA capable of washing hinotes and texts on his that resident makes a them. Resident also whead while they are givith resident and advivashing himself. Whe resident was starting the sident yelling at CNA trying to make CNA lefinished cleaning him about some shirts that had not came back ye some more shirts." ex	0:31 a.m.) Note Text: rrisonburg DSS services] for resident to esident stated that the bank re in both his name and er called [Name of staff] at [Phone number] and left by to obtain this information rotective order against 12:18 p.m.) Note Text: CNA eak with resident because to wash him. Resident is mself. Resident writes cell phone. CNA stated effort to expose himself to rill put his hands behind his ving care. This writer spoke sed that he is capable of n this writer left room	F60			
	that he would find son nurse explained that h himself, that we were was unable to do, he wear a gown, resident	was not helping him, and newhere else to go. this se could do some things for here to help him do what he stated he was not going to has issues with exposing to have staff provide care				

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (KI) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 495228 03/12/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION). CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 600 Continued From page 13 F 600 In genital area when he is capable of doing this himself. When staff is entering room, resident will place both hands behind his head. Resident stated that we get paid to wait on him. Resident stated that he is going to stay naked, that would get somebody's attention. Stating that he has not been able to see his psychlatrist, states he is going to call the advocate. Was very rude and disrespectful with CNA and this nurse. Notified Social Worker of same." - "12/31/2020 10:54 (10:54 a.m.) Note Text: Resident no longer on precautions so will be moved to [Room number on C hall]. Resident is aware and is own RR (resident representative)." - "1/12/2021 16:50 (4:50 p.m.) Note Text: CNA came to get this writer to listen to resident yell. CNA and this writer were at resident's door. Resident found on floor laying on right side. CNA stated that resident continues to make statements about throwing himself on the floor when he is mad. This writer called [Name of Physician] who gave verbal order to sent to ER (emergency room) for eval (evaluation) of fall and psych (psychiatric) eval. 911 called. This writer also spoke with LTC Ombudsman regarding resident. LTC Ombudsman stated that resident calls several times on multiple occasion." - "1/13/2021 07:05 (7:05 a.m.) Note Text: resident returned from ER at this time. No new orders received." - "1/13/2021 10:41 (10:41 a.m.) Note Text: Law enforcement officer in to serve protective order on resident from his wife." - "1/13/2021 14:57 (2:57 p.m.) Note Text: This

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CENTER	RS FOR MEDICARE &	MEDICAID SERVICES			OMB N	0, 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	PLE CONSTRUCTION G		E SURVEY PLETED
		495226	B. WING		0.3	3/12/2021
	ROVIDER OR SUPPLIER D NURSING AND REHAE	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 730 LUNENBURG HIGHW KEYSVILLE, VA 23847		712/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 600	resident. This writer a behaviors were unac resident that as of no source, that his Medifor LTC (long-term ca has sent his informati resident wanted to trabehavior, the other faresident due to his behavior, the other faresident due to his behavior tray, he had the "1/20/2021 07:55 (7 reported that when all dinner tray, he had the "1/23/2021 14:14 (2 rang call bell for tray CNA would be picking minutes. Because shaway he got angry arurine in floor in room. uncalled for, He state and he demands sen what we are getting pocial services. Mad bank and dmv. Expla nothing that myself of but that he did not had he did." -"1/27/2021 11:05 (1 to see this writer. Resfor CNA to clean up. I behavior issues. This call [Name of Deputy resident needs to be	ctor of nursing) in to talk with advised resident that his ceptable. Explained to whe also has no payer caid has not been approved are). Advised that this writer on to several facilities due to ansfer but because of his cilities refused to take shaviors." 155 a.m.) Note Text: CNA he went to pick up resident's rown it in the floor." 14 p.m.) Note Text: resident to be picked up, told him that a fall trays up in a few a did not go in room right had threw tray and urinal full of Told resident that was die has a mental problem vice right now. Stated that is haid for. Stated he would call because he cannot go to lined to him that there was a CNA could do about that we to act in the manner that a 1:05 a.m.) Note Text: CNA in his dent throwing tray in floor Resident continues to have writer received message to at sheriff's office due to	F6			

(licensed practical nurse) requested this writer to

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE AND PLAN OF CORRECTION DENTIFICATION NUMBER: A BUILDING		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		495226	a, WING			03/12/2021
	ROVIDER OR SUPPLIER D NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZII 730 LUNENBURG HIGHW KEYSVILLE, VA 23047	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 600	come in to resident riconversation with his ways to address contresident has been the floor because the (right) when he want observed meal tray at the resident had thray also has responsibility appropriately, resident as we have responsibility appropriately, resident stated to slichange him. CNA has most of day. CNA statement of time. Resident soon as he did, he resoiled brief in floor. On giving care to another soiled brief but residing to his room. CNA rounds with CNA from the cursing 2nd shift CN just came in room to "2/9/2021 10:14 (10) Resident removed feather trash can. Resident removed feather trash can. Resident removed feather trash can in room to "2/9/2021 10:14 (10) walking down hall he that he wanted her to into room to inquire or resident stated he ne asked again what the	moom as he had a mood address appropriate inplaints, per staff on unit reatening to throw himself on the staff are not coming in it is them to. This writer and trash all over the floor as swin it. Resident was advised consibilities toward him he ties as a resident to behave int verbalized understanding." 3:30 p.m.) Note Text: aff that she did not want to ad been in residents room atted that she has changed had soiled his brief and as amoved brief and threw CNA stated that she was ar resident at the time he and did not give CNA time to a on next shift was making in 1st shift, resident started A for no reason as she had do reporting rounds."	F	600		

STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION ABS228 MAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER WAYLAND NURSING AND REHABILITATION CENTER WAYLAND NURSING AND REHABILITATION CENTER WESTATEMENT OF DEFICIENCES TAGGET OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER WESTATE OF THE WAYLE OF THE	CENTER	S FUR MEDICARE-6	IMELITORID SERVICES				CIVIL MC	1. 0898-1951	
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MAKE OF PROMORER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER (AN JI) SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST SEE PRECEDED BY STULL PREFIX TAG FROM COntinued From page 16 proper hygiene every day that the CNA's bathed him. writer informed resident that she would have can set up his bath water, that he was more than capable of bathing himself. He stated "I didn't say I couldn": Then he stated that the needed to be changed, CNA was in room to change him when he starded yelling at her about the bath. Resident assured that the CNA's would be moving to (Room number) and will have a roommate. Resident on precautions." - "2/17/2021 10:25 (10:25 a.m.) Note Text: This writer mat with resident to advise would be moving to (Room number) and will have a roommate. Resident onto precautions." - "2/23/2021 13:43 (1:43 p.m.) Note Text: Activity Director reported hearing resident call CNA radial silurs and cursing her. CNA stated that she was going to provide him care as soon as she put the tray on the cart. Resident notinued to call CNA radial silurs and cursing her. CNA stated that she was going to provide him care as soon as she put the tray and curse her. This writer spoke with Administrator who went and advised resident that cursing and racial siurs and oursing her. CNA stated that she was going to provide him care as soon as she put the tray on the cart. Resident ontinued to call CNA radial silurs and curse her. This writer spoke with Administrator explain when he were attempted to but all facilities have declined due to resident's behavior." - "2/23/2021 14:11 (2:11 p.m.) Note Text: Staff stated that resident and advise that this is not			495226	B. WING			03/	12/2021	
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 800 Continued From page 16 proper hygiene every day that the CNA's bathed him. writer informed resident that she would have can set up his bath water, that he was more than capable of bathing himself. He stated "I didn't say I couldn't". Then he stated that he needed to be changed, CNA was in room to change him when he started yelling at her about the bath. Resident assured that the CNA would perform incontinent care on him and then set him up for bath." - "2/17/2021 10:25 (10:25 s.m.) Note Text: This writer mat with resident to advise would be moving to [Room number] and will have a roommate. Resident not on precautions." - "2/23/2021 13:43 (1:43 p.m.) Note Text: Activity Director reported hearing resident call CNA racial slurs and cursing her. CNA stated that she was going to provide him care as soon as she put the tray on the cart. Resident continued to call CNA racial slurs and curse her. This writer apoke with Administrator who went and advised resident that cursing and racial slurs would not be toferated. Resident stated find me another facility. Administrator explained that we have attempted to but all facilities have declined due to resident's behavior." - "2/23/2021 14:11 (2:11 p.m.) Note Text: Staff stated that resident continues to call CNA racial slurs and curse. Administrator again went to speak with resident and advise that this is not			ILITATION CENTER		730	LUNENBURG HIGHW	1		
proper hygiene every day that the CNA's bathed him. writer informed resident that she would have can set up his bath water, that he was more than capable of bathing himself. He stated "I didn't say I couldn't". Then he stated that he needed to be changed, CNA was in room to change him when he started yelling at her about the bath. Resident assured that the CNA would perform incontinent care on him and then set him up for bath." - "2/17/2021 10:25 (10:25 a.m.) Note Text: This writer met with resident to advise would be moving to (Room number) and will have a roommate. Resident not on precautions." - "2/23/2021 13:43 (1:43 p.m.) Note Text: Activity Director reported hearing resident call CNA racial slurs and cursing her. CNA stated that she was going to provide him care as soon as she put the tray on the cart. Resident continued to call CNA racial slur and curse her. This writer spoke with Administrator who went and advised resident that cursing and recial slurs would not be tolerated. Resident stated find me another facility. Administrator explained that we have attempted to but all facilities have declined due to resident's behavior." - "2/23/2021 14:11 (2:11 p.m.) Note Text: Staff stated that resident continues to call CNA racial slurs and curse. Administrator again went to speak with resident and advise that this is not	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	۲	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
- "2/28/2021 16:23 (4:23 p.m.) Note Text: resident arguing with his room mate over TV. Accused his roommate of being spoiled & babled by the staff. Stated he was going to "beat his {curse}" to his roommate Writer reminded resident that he was	F 600	proper hygiene every him. writer informed r can set up his bath w capable of bathing him I couldn't". Then he sichanged, CNA was in he started yelling at he assured that the CNA care on him and then - "2/17/2021 10:25 (11 writer met with reside moving to [Room num roommate. Resident r - "2/23/2021 13:43 (1: Director reported hea slurs and cursing her. going to provide him of tray on the cart. Resideratel alur and curse he Administrator who we cursing and racial slur Resident stated find in Administrator explained to but all facilities have behavior." - "2/23/2021 14:11 (2: stated that resident calculated that resident calculated that resident and acceptable behavior." - "2/28/2021 16:23 (4: arguing with his room roommate of being sp Stated he was going it	day that the CNA's bathed esident that she would have ater, that he was more than mself. He stated "I didn't say tated that he needed to be proom to change him when er about the bath. Resident towould perform incontinent set him up for bath." 10:25 a.m.) Note Text: This into advise would be abord and will have a mot on precautions." 143 p.m.) Note Text: Activity ring resident call CNA racial CNA stated that she was care as soon as she put the dent continued to call CNA her. This writer spoke with ant and advised resident that its would not be tolerated. The another facility, and that we have attempted a declined due to resident's 11 p.m.) Note Text: Staff continues to call CNA racial inistrator again went to and advise that this is not 23 p.m.) Note Text: resident mate over TV. Accused his holled & babied by the staff, to "beat his {curse}" to his	F	500				

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CENTERS FOR MEDICARE & MEDICARD SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER. A. BUILDING B. WING 495226 03/12/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) GROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 600 | Continued From page 17 F 600 not able to ambulate or transfer alone. Writer encouraged resident to try to work toward compromise with the TV & share what programs are watched, perhaps take turns. Also explained to him that the staff provide his room mate with time to smoke because it is the roommates right to smoke. It is also the roommates right to have the staff do shopping for him, resident was encouraged to let the activity department know if he wanted items purchased for him at the store on resident shopping day, explained he needed to have funds in his account & that they could find that out for him on Monday. Writer encouraged resident to try to speak nicely & politely to his room mate & to other resident's & staff. Reminded him that polite people do not throw things & yell at others during conversation. Resident stated that he wanted to leave writer explained that the social service department has been trying to find alternate placement for him however due to his behaviors other facilitates are not agreeing to having him transfer there." - "3/1/2021 10:00 (10:00 a.m.) Note Text: On 2/28/21 at approximately 1640 hours (4:40 p.m.) writer was called to resident's room. Resident's roommate [Resident #4] had sustained a 6.5cm (centimeter) laceration on his right lateral lower leg. The room mate [Resident #4] states that this resident [Resident #37] pushed the w/c (wheelchair) that was next to his bed (observed w/c on the left side of this resident's bed) into the privacy curtain pushing the overbed table into his leg. Roommate [Resident #4] yelling he was going to call the police; this resident [Resident #37) yelling "I didn't do anything, I'm calling my dad to pick me up before the cops come. I'm not going to jail". Resident [Resident #37] observed to be rolling onto his side reaching for the w/c

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CENTER	S PUR MEDICARE &	MEDICAID SERVICES			OMB NO. 0038-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495226	B. WNG		03/12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAE	SLITATION CENTER	730	REET ADDRESS, CITY, STATE, ZIP CODE D LUNENBURG HIGHW CYSVILLE, VA 23947	00/18/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
F 600	Continued From page again. Writer remove placed in the hallway the floor for safety. We stop trying to roll out back & be still. No ob altercation." -"3/1/2021 16:20 (4:2 called code green amon the floor. Upon en lying on his back perpethe foot of the bed. POLICE DON'T BELI Resident reports back now position. RN (proom with equipment his legs thrown over the stated he was leaving to bed. Resident has to harm himself or other was called for transport to the evaluation of back path health eval as there is was called for transport in the stated he was the relieves called for transport in the stated he was the relieves called for transport in the stated he was to the er. Reside agitated and stated he (against medical advised him to Jail.	d w/c from the room & & resident bed lowered to friter instructed resident to of the bed & to lay on his servable injury from 20 p.m.) Note Text: staff d stated resident was lying tering room resident was pendicular to the bed below esident stated "THE EVE I CAN'T WALK". It pain. Resident was log moving all extremities. I back into bed by staff. Bed registered nurse) returned to to obtain vitals- resident had the side of the bed and p. Assisted resident back in no where to go and is at risk ners." 20 p.m.) Note Text: MD ctor) was notified of incident. The cer (emergency room) for in post fall and for mental as concern for his eafety. 911 out to er, report was called to time of Hospital) er. Resident	F 600		
ORM CMS-256		xplained to resident that we	7X11 Facili	ity ID: VA0050 If con	tinuation sheet Page 19 of 9

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO	0. 0938-0391	
STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
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NAME OF PROVIDER OR WAYLAND NURSING		ILITATION CENTER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	9E	(X5) COMPLETION DATE
are sending safety. Resconsented in the protective resident to the control of the protective resident to the control of the protective resident to the control of the control of the protective resident to the control of the protective resident if	escue squared to go to the state of the stat	e er for concern for his d'arrived and resident e er" 31 p.m.) Note Text: uty in to speak with resident sling incident of 2/28/21." 32 a.m.) Note Text: buty in to serve resident esault charges on another]. Also was served a list him taken out by his wife. 37] after deputy left threw This writer in to speak with e did not bother the other ined that it was from the lused the other resident to have 9 staples in leg." 34 a.m.) Note Text: Housekeeping Supervisor t stated that he wanted to over with. Writer asked an. Received no response. ADON (assistant director of I doctor) made aware.	F	600			

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CENTERO FOR WEDICARE & WE	DICHID SERVICES				OMBING	0. 0938-0394
STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495228	B. WING		The state of the s	0.3	/12/2021
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILIT.	ATION CENTER		7:	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW (EYSVILLE, VA 23947		TAIAVA
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES IST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 600 Continued From page 20 well with his family. Reporestraining order against anger issues and it upset not hit her. Family does not throw anything. He discusse his urinal was not throw anything. He discussed his urinal was not throw anything. He discussed intermittent dependent intermittent inte	orts his wife has a him because, "I have ther". Reports he did not visit" agement note dated 37 documented in part, staff last evening of close enough. He did enles any recent sexual dical) management note ent #37 documented in ay for a flu (follow up) for pression, anxiety, sexual use that have been as thrown his table in they have set limits and approved. per staff, his er against him for not take him back due to armily and children in the in safety, please send to rement) for evaluation. In the proved in the proved in the safety of the safety and children in the in safety of the safety and the frustration and aff. Maintain sexual the safety 2:00 p.m., an with OSM (other staff less. OSM #5 stated that meeting with the sembers of the SM #5 stated that when noved to another room	F	600			

CITIALITI	WILLIAME OF WELL	MICHICAID SCHAICES				CHRIST	7 05596-0231
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	, , , , , , , , , , , , , , , , , , , ,		ONSTRUCTION		: SURVEY PLETED
		495226	B. WING		***************************************	03.	/12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		730	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW YSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTHYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
	room mate for the res #5 stated that they ta they thought would ha get along when assig stated that Resident # hallway in a private ro for the required amout that after the quaranti Resident #37 was mo Resident #4 on the A where Resident #4 wi #5 stated that Reside inappropriate behavior were admitted. OSM displayed verbally abit exposed himself to fee think that those behavior stated that those behavior resident. OSM #5 sta Resident #37 and Resident. OSM #5 sta declities at Resident # none would accept the OSM #5 stated that Re yelling at another resi OSM #5 stated that we incident occurred the intervene and separat asked if Resident #37 to consideration wher with Resident #4, OSI thought that the reside #5 stated that there w 2/17/21 and Resident been placed in a roon	dident in the meetings. OSM liked about which residents are common interests and ning room mates. OSM #5 #37 was admitted to the C from and was on quarantine int of time. OSM #5 stated ne period was over eved into the room with hallway for long term care as already residing. OSM int #37 started displaying are a few days after they #5 stated that Resident #37 usive behaviors to staff and male staff but they did not viors would transfer to a sted that they had hoped that sident #4 would get along oth cognitively intact and mon interests. OSM #5 ent out requests to other #37's request for transfer but em due to his behaviors. esident #4 had a history of dent and slamming doors, then a resident to resident staff were to immediately the the residents. When its behaviors were taken in a placing him in the room M #5 stated that they ents would get along. OSM for each other empty beds on #37 could possibly have in by himself.	F	600			
	On 3/10/21 at approxi interview was conduct	mately 2:34 p.m., an ted with RN (registered					

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CENTER	COLOR MITHICARE &	MEDICAID SERVICES			OM	8 NO. 0938 0391	
	OF OEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495226	B. WING			03/12/2021	
NAME OF P	ROVIDER OR SUPPLIER .			STREET ADDRESS, CITY, STATE, ZIP CO	/DE		
				730 LUNENBURG HIGHW			
WAYLAND	NURSING AND REHAB	ILITATION CENTER		KEYSVILLE, VA 23947			
	CUMMADY BT	ATTUENT OF OPENINGER					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	PRÉFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	GOMPLETION DATE	
F 600	Continued From page nurse) #1. RN #1 sta asked to go to Reside room because a staff arguing about the tele #1 stated that when a residents were not tal pulled between them. the residents that they the television and their RN #1 stated that they on TV shows and both on the idea so she left incident. RN #1 state nurses station and state called back to the room a few minutes later. Fentered the room Resident #37 and Resident #37 and Resident #37 and Resident #4 but had not shown an #1 stated that the includent in the staff had reported #37 and Resident #4 but had not shown an #1 stated that the includent for the day shift. RN # she did was to mainta Resident #4 to ER and ambulance arrived. R #4 had not been sent separated the two resident about the prograt 4:23 p.m. which doot threatening to "beat himmediately prior to the immediately prior to the resident #4 in the immediately prior to the sked about the prograt 4:23 p.m. which doot threatening to "beat himmediately prior to the sked about the prograt 4:23 p.m. which doot threatening to "beat himmediately prior to the sked about the prograt 4:23 p.m. which doot threatening to "beat himmediately prior to the sked about the prograt 4:23 p.m. which doot threatening to "beat himmediately prior to the sked about the prograt 4:23 p.m. which doot threatening to "beat himmediately prior to the sked about the prograt 4:23 p.m. which doot threatening to "beat himmediately prior to the sked about the prograt 4:23 p.m.	ted that on 2/28/21 she was ant #37 and Resident #4's member could hear them evision from the hallway. RN he entered the room the king and the curtain was RN #1 stated that she told whad been arguing about in they began arguing again was a table to agree to the room to document the distance of the room to document the distance when they are the room to document the distance when they are the room to document the distance when they are the room to document the distance when they are the room to document the distance when they are the room the second time sident #4 had their leg over bleeding. RN #1 stated if the room the second time sident #4 were arguing that Resident #37 was lying to them that both Resident had been blokering all day by physical aggression. RN dent occurred near the end 1 stated that the first thing in safety so she sent distance that the first thing in safety so she sent distance that the the ER, she would have idents at that time. When the safety are the room the sident #37 is (Resident #4's) [curse]," the physical altercation, RN is reminded Resident #37	F 60	DEFICIENCY			
		I #1 stated that in hindsight,					

CHENTED	OF LOIS MEDICANTE R	MICHALOROVIED GELLAIDED			CHAIR LACE CHARLEDGE	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED	
	5	495226	B. WING	gjer frysjolog ge geg a gegellediskelebuiken fellest o "A 1981 belef belef belef belef belef belef belef belef	03/12/2021	
	ROVIDER OR SUPPLIER D NURSING AND REHAI	BILITATION CENTER	730 L	ET ADDRESS, CITY, STATE, ZIP CODE .UNENBURG HIGHW SVILLE, VA 23947	Bendergen and deliver with a second and a second	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 600	have separated the arguing. RN #1 state Resident #37 was phas well as he did or to Resident #4. RN Resident #37 was arfrequently did and won any physical viole. The facility daily cenfollowing: - 43 empty beds in the Ahall and 20 empty - 42 empty beds in the Ahall and 20 empty - 41 empty beds in the Ahall and 24 empty beds in the hall and 25 empty beds in the hall and 26 empty beds in the hall and 27 empty beds in the hall and 28 empty beds in the hall and 29 empty beds in the hall and 20 empty beds in the h	sident #4 and she should esidents when they were ed that she did not think hysically capable of moving being able to cause the injury #1 stated that she thought agry and just talking as he as not able to follow through ince. sus documented the se facility, 13 empty beds on beds on C hall on 2/15/2021. The facility, 12 empty beds on A add on C hall on 2/16/2021. The facility, 9 empty beds on A add on C hall on 2/17/2021. The facility, 9 empty beds on A add on C hall on 2/18/2021. The facility, 8 empty beds on A add on C hall on 2/19/2021. The facility, 8 empty beds on A add on C hall on 2/19/2021. The facility, 8 empty beds on A add on C hall on 2/19/2021. The facility as empty beds on A add on C hall on 2/19/2021. The sident to resident with the sident #37] was involved and #41] regarding TV and	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARIS & MEDICARIS & MEDICARIS SERVICES

PRINTED: 03/17/2021 FORM APPROVED

BATTEMENT OF DEPLICENCES AND PLAN OF CORRECTION ONLY LEGISLATION ABURDER. AND PLAN OF CORRECTION ARE OF PROMDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER WAYLAND NURSING AND REHABILITATION CENTER WEYSPILLE, VA. 3947 FREDIX STREET ADDRESS, CITY, STATE, DP CODE TO LINERABURGH RIGHW KEYSPILLE, VA. 3947 FREDIX STREET ADDRESS, CITY, STATE, DP CODE TO LINERABURGH RIGHW KEYSPILLE, VA. 3947 FREDIX STREET ADDRESS, CITY, STATE, DP CODE TO LINERABURGH RIGHW KEYSPILLE, VA. 3947 FREDIX STREET ADDRESS, CITY, STATE, DP CODE TO LINERABURGH RIGHW KEYSPILLE, VA. 3947 FREDIX STREET ADDRESS, CITY, STATE, DP CODE TO LINERABURGH RIGHW KEYSPILLE, VA. 3947 FREDIX STREET ADDRESS, CITY, STATE, DP CODE TO LINERABURGH RIGHW KEYSPILLE, VA. 3947 FROMDER'S RAN OF CORRECTION FREDIX STREET ADDRESS, CITY, STATE, DP CODE TO LINERABURGH RIGHW KEYSPILLE, VA. 3947 FROMDER'S RAN OF CORRECTION FREDIX STREET ADDRESS, CITY, STATE, DP CODE TO CORRECTION FROMDER'S RAN OF CORRECTION FROMDER'S REFERENCED TO THE APPROPRIATE CENTER OF THE ADDRESS AND OF CORRECTION FREDIX STREET ADDRESS, CITY, STATE, DP CODE TO CORRECTION FROM THE ADDRESS AND OF CORRECTION FROM THE ADDRE	CENTER	S CONTRICTORANTE OF	MILLIOVID SERVICES				CIMITIM	0 0838-0381	
WAYLAND NURSING AND REHABILITATION CENTER WAYLAND MURSING AND REHABILITATION CENTER (X4) D SUMMARY STATEMENT OF DESIGNATION REGULATORY OR LSC DENTIFYING INFORMATION) FOR PREFIX TAG Continued From page 24 private room away from [Resident #37]. The Chariotte County Sheriffs department was notified and a complaint was liked by [Resident #4] against [Resident #37]. Papers were served on [Resident #37] to asseult on 3/2/21See attached POC" The attached plan of correction summary documented as detailed summary of the incident details describing the residents involved, a summary of actions taken by the facility to prevent a recurrence, the facility procedure for monitoring the plan of correction and the person responsible for implamenting the plan of correction. The Final Compliance date documented was 3/2/2021. On 3/10/21 at approximately 12:30 p.m., a request was made to ASM (administrative staff member) #2, the director of nursing for all documentation and investigation for the resident-lo-resident incident to 2/28/21 for Resident #4 and Resident #37. SM #2 stated that the facility had completed a FRI (facility reported incidenty with investigation and had completed a plan of correction including education, interviews with residents, staff abuse testing, sudits and the plan to monitor the plan of correction. ASM #2 stated that the yould provide the evidence for review. On 3/10/2021 at approximately 1:30 p.m., ASM #2, the director of nursing presented a binder, which documented the following: - Interviews completed by the social worker of all cognitively intact residents in the facility on 3/2/21 regarding abuse.				1, ,					
WAYLAND NURSING AND REHABILITATION CENTER WAYLAND NURSING AND REHABILITATION CENTER ### TO LUNNINUMON HIGHW KEYSVILLE, VA. 23947 FREDIX TAG Continued From page 24 private room away from (Resident #37]. The Charlotte County Sheriffs department was notified and a completin was fleed by [Resident #4] against [Resident #37]. Papers were served on (Resident #37] for assault on 37/2/21See attached POC" The attached plan of correction summary documented a detailed summary of the incident details describing the residents involved, a summary of actions taken by the facility to prevent a recurrence, the facility procedure for monitoring the plan of correction and the person responsible for implementing the plan of correction. The Final Compliance date documented was 3/2/2021. On 3/10/201 at approximately 12:30 p.m., a request was made to ASM (administrative staff member) #2, the director of nursing for all documentation and investigation for the resident-to-resident incident on 2/2/21 for Resident #4 and Resident #37. ASM #2 stated that the facility had completed a FRI (facility reported incident) with investigation and had completed a plan of correction including education, interviews with residents, staff abuse testing, audits and the plan to monitor the plan of correction. ASM #2 stated that they would provide the evidence for review. On 3/10/2021 at approximately 1:30 p.m., ASM #2, the director of nursing presented a binder, which documented the following: - Interviews completed by the social worker of all cognitively intact residents in the facility on 3/2/21 regarding abuse.			495226	B. WNG_		days demonstrate and the filter and the second of the seco	03	/12/2021	
PREFIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION F 600 Continued From page 24 private room sway from [Resident #37]. The Charlotte County Shariffs department was notified and a complaint was flied by [Resident #4] against [Resident #37]. Papers were served on [Resident #37] for assault on 3/2/21See attached POC" The attached plan of correction summary documented a clasified summary of the Incident details describing the residents involved, a summary of actions taken by the facility to prevent a recurrence, the facility procedure for monitoring the plan of correction and the person responsible for implementing the plan of correction and the person responsible for implementing the plan of correction. The Final Compliance date documented was 3/2/2021. On 3/10/21 at approximately 12:30 p.m., a request was made to ASM (administrative staff member) #2, the director of nursing for all documentation and investigation for the resident-to-resident incident on 2/28/21 for Resident #4 and Resident #37. ASM #2 stated that the facility had completed a FRI (facility reported incident) with investigation and had completed a plan of correction including education, intorviews with residents, staff abuse testing, audits and the plan to monitor the plan of correction. ASM #2 stated that they would provide the evidence for review. On 3/10/2021 at approximately 1:30 p.m., ASM #2, the director of nursing presented a binder, which documented the following: - Interviews completed by the social worker of all cognitively infact residents in the facility on 3/2/21 regarding abuse.			ILITATION CENTER		730	LUNENBURG HIGHW			
private room away from [Resident #37]. The Charlotte County Sheriffs department was notified and a complaint was flied by [Resident #44] against [Resident #37]. Papers were served on [Resident #37]. Papers were served on [Resident #37] for assault on 3/2/21See attached POC" The attached plan of correction summary documented a detailed summary of the Incident details describing the residents involved, a summary of actions taken by the facility to prevent a recurrence, the facility procedure for monitoring the plan of correction and the person responsible for implementing the plan of correction. The Final Compliance date documented was 3/2/2021. On 3/10/21 at approximately 12:30 p.m., a request was made to ASM (administrative staff member) #2. the director of nursing for all documentation and investigation for the resident-lo-resident incident on 2/28/21 for Resident #4 and Resident #37. ASM #2 stated that the facility had completed a FRI (facility reported incident) with investigation and had completed a plan of correction including aducation, interviews with residents, staff abuse testing, audits and the plan to monitor the plan of correction. ASM #2 stated that they would provide the evidence for review. On 3/10/2021 at approximately 1:30 p.m., ASM #2, the director of nursing presented a binder, which documented the following: - Interviews completed by the social worker of all cognitively intact residents in the facility on 3/2/21 regarding abuse.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI	BE.	COMPLETION	
- An audit of any resident-to-resident altercations		private room away from Charlotte County She and a complaint was a against [Resident #37] [Resident #37] for assattached POC" The attached plan of a documented a detailed details describing the summary of actions tap revent a recurrence, monitoring the plan of responsible for implementation. The Final documented was 3/2/2 on 3/10/21 at approximate request was made to member) #2, the direct documentation and invesident-to-resident in Resident #4 and Reside	m [Resident #37]. The riffs department was notified filed by [Resident #4]]. Papers were served on eault on 3/2/21See correction summary of the incident residents involved, a sken by the facility to the facility procedure for correction and the personmenting the plan of Compliance date 2021. mately 12:30 p.m., a ASM (administrative staff for of nursing for all vestigation for the cident on 2/28/21 for dent #37. ASM #2 stated investigation and had prection including with residents, staff abuse plan to monitor the plan of stated that they would for review. Eximately 1:30 p.m., ASM sing presented a binder, a following: If by the social worker of all ents in the facility on 3/2/21	F 6	000				

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) ARTI TIDI	F CONSTRUCTION	(X3) DATE SURVEY	
	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		495226	8. WING		03/12/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
IAFAVI AKIS	NURSING AND REHAB	II ITATION CENTED		730 LUNENBURG HIGHW		
VVATLANL	MOKSING AND REAMS	ILITATION CENTER		KEYSVILLE, VA 23947		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ΙĐ	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF		
IAG	110000110111 0111	and local and the state of the	ing	DEFICIENCY)		
				[
F 600	Continued From page	25	F 60			
		s at the facility. No other				
	incidents were identifi	•	•	9		
	- Staff In-service sign	in sheets.				
	- Copies of envelopes		ł			
		buse mailed to staff not				
	currently working at th	ne facility.				
	- Resident to Residen	t abuse quizzes completed		· revealed		
	by staff.					
	- Incident reports for e	auch resident dated				
	2/28/2021			=1		
		immary completed by the				
	Director of Nursing,					
1	- Witness statements.					
	The binder further doc	cumented a Quality				
		mance Improvement Plan				
	dated 3/2/21 documer		İ			
		ove and monitoring. It				
		10% of residents with a			and the state of t	
		bove will be interviewed by				
	the facility Social World	kers utilizing the Resident				
	Abuse Audit Tool wee	kly x 4 weeks beginning on				
	3/3/21 to ensure that i	resident to resident				
	-	addressed appropriately.			A - Bit was	
	The Quality Assurance					
		taff members using the				
į	,	aire weekly X 4 weeks to				
		ers are informed of the				i
	proper interventions for					
ļ		ninistrator or Director of				
	- '	view and initial Resident	1			
		use Quiz questionnaires	[
		nsure completion and all addressed appropriately.				
		forward the results of the		-		
	Resident Interview To					
	questionnaires to the					
		or issues that may need				
		ut in place and to determine				
1	runner interventions p	arm blace and to detailling			1	

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			0	MB NO 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTI A, BUILDIN	PLE CONSTRUCTION G		(3) DATE SURVEY COMPLETED	
		495226	B. WING _			03/12/2021	
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STAT 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	E, ZIP CODE	03/12/2021	-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT) CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
	The other points of the described in this writing resident interviews an concerns were identified. The facility policy "Abit Misappropriation of Real a revision date of 3/10 "The facility believes to right to be free from all seclusion, exploitation property. The facility control to prevent mission exploitation, and abusing misappropriation of the access [sic], care plan with needs and behave abuse, neglect, or mission of the access [sic], are plan with needs and behave abuse, neglect, or mission of the access [sic], and plan with needs and behave abuse, neglect, or mission of the access [sic], and plan with needs and behave abuse, neglect, or mission of the access [sic], and plan with needs and behave abuse, neglect, or mission of the access [sic], and plan with needs and behave abuse, neglect, or mission of the access [sic], and plan with needs and behave abuse, neglect, or mission of the access [sic], and plan with needs and behave abuse, neglect, or mission of the access [sic], and plan with needs and behave abuse, neglect, or mission of the access [sic], and plan with needs and behave abuse, neglect, or mission of the access [sic], and plan with needs and behave abuse, neglect, or mission of the access [sic], and plan with needs and behave abuse, neglect, or mission of the access [sic], and plan with needs and plan with	ts for the buse inservice were by multiple staff interviews a plan of correction as an of were verified with dispervations. No ed. use, Neglect, or esident Property Policy" with 0/2017 documented in part, hat our residents have the buse, neglect, involuntary a, or misappropriation of will do whatever is in its treatment, neglect, e of our residents or elir propertyThe facility will a, and monitor residents iors that might lead to appropriation of property" eximately 4:30 p.m., ASM ember) #1, the director of nursing and ansultant were notified of the of harm at past	F6	00			
	1. Chronic obstructive	pulmonary disease					ŀ

CENTER	IS FOR MEDICARE &	MEDICAID SERVICES			OA	MB NO.	0938-0391	
	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495226	B. WING			03/1	2/2021	
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		73	REET ADDRESS, CITY, STATE, ZIP CODE 10 LUNENBURG HIGHW EYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 600	that can lead to short information was obtain	t makes it difficult to breath	F6	000		men's bare they make the control of		
F 623 SS=D	the heart can't pump body's needs. Heart f your heart has stoppe working. It means that pump blood the way it both sides of the heart obtained from the well https://medlineplus.gd. 3. Parkinson's diseast disorder. This inform website: https://www.nlm.nih.gsease.html. 4. Anxiety -Fear. This from the website: https://www.nlm.nih.gsease.html.	t your heart is not able to t should. It can affect one or t. This information was usite: by/heartfallure.html te- a type of movement ation was obtained from the ov/medlineplus/parkinsonsdi s Information was obtained ov/medlineplus/anxiety.html Before Transfer/Discharge (6)(8) pefore transfer. fers or discharges a fust-	F	523	F 623- Resident #41 & #2 have been readmitted to facility. The Ombudsman w notified of resident #41 and #2 previous discharges on 3/12/21 by the Social Work- An audit of all transfers in the lated and any identified areas of concern have corrected and the Ombudsman has been notified. The audit was completed on 3/24- The Social Worker has been inserviced on 3/24/21 by the Director of Nu on the Virginia Bed-hold and Transfer policy.	ker. est 30 Worker been 1 4/21. ursing		
	the reasons for the m	r they understand. The oppy of the notice to a			The SW will provide written notification to Ombudsman of any facility transfer/disch Documentation will be entered into the cll record by the SW of the bed-hold policy of to the resident or RR and the notification Ombudsman.	narge. linical given		

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495226	B. WING	_		03/	12/2021
	ROVIDER OR SUPPLIER D NURSING AND REHAB SUMMARY ST	ILITATION CENTER	ID	73	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LUNENBURG HIGHW EYSVILLE, VA 23947 PROVIDER'S PLAN OF CORRECTION		Q(S)
PREFIX TAG		MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PRCFI	'	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION CATE
	accordance with para- and (iii) Include in the notic paragraph (c)(5) of the §483.15(c)(4) Timing (I) Except as specified (c)(8) of this section, to discharge required un made by the facility at resident is transferred (ii) Notice must be ma before transfer or disc (A) The safety of indiv be endangered under this section; (B) The health of indiv be endangered, under this section; (C) The resident's hea allow a more immedia under paragraph (c)(1 (D) An immediate tran required by the reside under paragraph (c)(1 (E) A resident has not days. §483.15(c)(5) Content notice specified in par must include the follow (I) The reason for tran	s for the transfer or sent's medical record in graph (c)(2) of this section; ce the Items described in a section. of the notice. I in paragraphs (c)(4)(ii) and the notice of transfer or der this section must be least 30 days before the or discharged. de as soon as practicable tharge when-iduals in the facility would paragraph (c)(1)(i)(C) of iduals in the facility would paragraph (c)(1)(i)(D) of iduals in the facility would the paragraph (c)(1)(i)(D) of iduals in the facility would the paragraph (c)(1)(i)(D) of iduals in the facility would the paragraph (c)(1)(i)(D) of iduals in the facility would the paragraph (c)(1)(i)(D) of iduals in the facility would the paragraph (c)(1)(i)(i)(i)(i)(i)(i)(i)(i)(i)(i)(i)(i)(i)	F	523	Continued from page 28 Transfers and Discharges will reviewed by the Nurse Managers Mon Friday weekly x 4 weeks during the Ca IDT meeting using the Transfer/Discha Audit tool. Any areas of concern identified given to the Social Worker for correland notification to the Ombudsman. The findings of the Transfer/Discharge audit tool with be reviewed the monthly QAPI meeting x 1 month.	day- irdinal irge fied will ection	04/12/21

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB F	VO 0938-0391
	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495226	B, WING			0	3/12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		730	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW /SVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LO BE	(X5) COMPLETION DATE
F 623	including the name, a and telephone number receives such reques to obtain an appeal for completing the form a hearing request; (v) The name, addres telephone number of Long-Term Care Omb (vi) For nursing facility and developmental disabilities, the malling telephone number of the protection and addevelopmental disabilities, the malling telephone number of the protection and addevelopmental disabilities of the Developmental disability. For nursing facility disorder or related disemail address and telegency responsible for advocacy of individual established under the for Mentally III Individual S483.15(c)(6) Change If the information in the effecting the transfer of must update the recip as practicable once the becomes available. \$483.15(c)(8) Notice in the case of facility of the administrator of the	e resident's appeal rights, ddress (mailing and email), prof the entity which ts; and information on how orm and assistance in and submitting the appeal is (mailing and email) and the Office of the State and the agency residents with intellectual sabilities or related grand email address and the agency responsible for a cocacy of individuals with all Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and a gresidents with a mental abilities, the mailing and ephone number of the or the protection and als with a mental disorder Protection and Advocacy uals Act.	F	623			

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

	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	LTIPLE CONSTRUCTION	197	DATE SURVEY COMPLETED	
l		495226	B. WNG			03/12/2021	
	OF PROVIDER OR SUPPLIER AND NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) PREF TAC	IX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE ACTION SHO	38 Q.IUC	(XS) COMPLETION DATE	
F6	to the State Survey A State Long-Term Can the facility, and the re well as the plan for th relocation of the resid 483.70(I). This REQUIREMENT by: Based on staff intervi review, and clinical re determined that the fa notification to the omb discharge from the fac in the survey sample, The facility staff failed notification to the omb and Resident #2's trai facility on 1/28/21. The findings include: 1. The falled to eviden notified of Resident #4 sister facility on 1/28/2 Resident #41 was adn 8/7/2020 with a recent with diagnoses that in to: high blood pressur condition in which hen blood vessels of the b and resulting symptom move a body part [as or to speak, paralysis death) (1) and dement mental decline, especi	gency, the Office of the a Ombudsman, residents of sident representatives, as a transfer and adequate ents, as required at § is not met as evidenced ew, facility document cord review, it was acility staff failed to evidence and sman of a resident cility for two of 35 residents. Residents #41 and #2. It to evidence written and sman for Resident #41's ansfer/discharge to a sister and the small state of the facility on a readmission on 2/12/2021, cluded but were not limited.	F	623			

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				QMB N	IO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(-)		CONSTRUCTION		TE SURVEY MPLETED
		495226	8, WING		<u> </u>	0:	3/12/2021
	ROVIDER OR SUPPLIER D NURSING AND REHAB	ILITATION CENTER	<u> </u>	730	REET ADDRESS, CITY, STATE, ZIP CODE D LUNENBURG HIGHW LYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD 8E	COMPLETION DATE
F 623	Continued From page The most recent MDS assessment, a quarte assessment reference the resident as scorin interview for mental is resident was moderal cognitive decisions, requiring extensive as member for moving in coded as not moving the lookback period. Devices, the resident wheelchair. A review of Resident sheet revealed that sl facility on 1/28/21, an A review of Resident revealed a progress of progress note stated discharged to a sister (3) diagnosis on 1/28/ readmitted on 2/12/21	6 31 6 (minimum data set) 11		623		PRIATE	OATE
	staff member) #1, the director of nursing, A consultant, and ASM: vice-president, were it ASM #3 was asked at follows when a reside	m., ASM (administrative administrator, ASM #2, the SM #3, the clinical #4, the regional informed of these concerns. bout the process staff in is discharged from a transfer/discharge to a		and dely made to this for the con-			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
		495226	B. WNG			03/	12/2021	
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		730	REET ADDRESS, CITY, STATE, ZIP CODE D LUNENBURG HIGHW LYSVILLE, VA 23947	1	Tarran V p. 1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 623	working to "expedite" facility where they we accepting facility as a there were many pleor many phone calls lived discharge/transfer promade a packet of info included all of the reg stated, however, that paperwork packet. She could not produce evided been notified of the A review of the facility Transfer," revealed, in transfer to other medically at the attending physicial transferred or discharge nursing home, a copy and referral record an medical information, a receiving the resident, No further information REFERENCES (1) Barron's Dictionary Non-Medical Reader, Chapman, page 114. (2) Barron's Dictionary Non-Medical Reader, Chapman, page 124.	getting residents out of the re and getting to the on as possible. She stated es of documentation and olived in the ocess. ASM #3 stated, "We rmation, which should have ulatory paperwork." She the facility did not retain the e also stated that the facility dence that the ombudsmen he transfer/discharge. policy, "Discharge and part: "Discharge	F	523				

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDE	TIPLE CONSTRUCTION MG		(X3) DATE COMP	SURVEY LETED
		495226	B. WING	appening allefaller a seem		03/	12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	DDE		
(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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE
F 623	Continued From page outbreak of respiratur detected in Wuhan, C SARSCOV-2. (Former 2019-nCoV.) The disc SARS-CoV-2 has beeinformation was obtainttps://www.nccih.nih.navirus-and-alternativ 2. The failed to evider notified of Resident #2 slster facility on 1/28/2 Resident #2 was admand was recently reacting dementia (a progressi especially memory fur accompanied by disorpressure and schizopimental disorders chardistortions of reality, vianguage, perception (2). The most recent MDS assessment, a signific with an assessment recoded Resident #2 as short or long-term me resident was coded as assistance of one staf bed. Resident #2 was	y Illness in people first thina, has been named rily, it was referred to as been caused by an named COVID-19." This ned from the website: gov/health/in-the-news-coro re-treatments: Ince ombudsman was not 2's transfer/discharge to a 21. Itted to the facility 5/17/2015 Imitted on 2/23/2021 with ad but were not limited to: we state of mental decline, nection and judgement, often rilentation.)(1), high blood hirenia (Any of a group of acterized by gross withdrawal of thought, and emotional response) I (minimum data set) cant. change assessment, reference date of 3/2/2021, having no difficulty with mory difficulties. The					
	their room or unit. In S Devices, the resident wheelchair.	Section G0600 - Mobility was coded as using a					
ORM CMS-258	A review of Resident # 7(02-90) Provious Versions Obso	#2's clinical record revealed blate Event ID: 087X11		Facility ID. VA0050	If continu	Intion sheet	Page 34 of 95

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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	B. WING			03.	/12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		730	REET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW YSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	stated the resident has sister facility due to a 1/28/21, and was bein her home facility. Further review of Res failed to reveal evident was notified of Reside on 1/28/21. On 3/11/21 at 2:00 p.r. staff member) #1, the director of nursing, Acconsultant, and ASM avice-president, were in ASM #3 was asked at follows when a reside facility - even if it is a sister facility. ASM #3 working to "expedite" facility where they were accepting facility as so there were many piecemany phone calls invodischarge/transfer promade a packet of infoincluded all of the registated, however, that it paperwork packet. She could not produce evided been notified of the No further information.	d 2/23/21. The progress note d been discharged to a COVID-19 (3) diagnosis on a greadmitted on 2/23/21 to dident #2's clinical record ace that the ombudsman ent #2's transfer/ discharge ent #2's transfer/ discharge ent #2's transfer/ discharge ent #2, the SM #3, the clinical end ent #4, the regional ent	I.	623			

PRINTED: 03/17/2021 OMB NO: 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE : COMPL	
		495226	B. WING		03/1	12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAE	ILITATION CENTER	7	STREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625 SS=D	Non-Medical Reader, Chapman, page 522. (3) "Coronaviruses ar found in many differe including camels, cat of coronavirus identification of the coronavirus and alternation was obtain the coronavirus and alternation of the coronavirus and alternation of the coronavirus and coronavirus and coronavirus and coronavirus facility transfet the resident goes on coronavirus facility must proceed the coronavirus facility in the coronavirus facility; (ii) The reserve bed polan, under § 447.40 (iii) The nursing facility bed-hold periods, which paragraph (e)(1) of the resident to return; and	y of Medical Terms for the .5th edition, Rothenberg and re a large family of viruses nt species of animals, the, and bats. The new strain ed as the cause of the y illness in people first china, has been named rly, it was referred to as ease caused by en named COVID-19." This ned from the website: .gov/health/in-the-news-coro ve-treatments olicy Before/Upon Trnsfr (2) Ded-hold policy and return- before transfer. Before a ers a resident to a hospital or therapeutic leave, the provide written information to nt representative that e state bed-hold policy, if resident is permitted to sidence in the nursing ayment policy in the state of this chapter, if any; y's policies regarding ch must be consistent with is section, permitting a	F 625	F 625- Resident #41 & #2 have been readmitted to facility.	ern tified in by the hold vide to the li be urse of esident be rdinal rge	04/12/21

FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495226	B. WING			03/	12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE	
F 625	of this section. §483.15(d)(2) Bed-ho the time of transfer of hospitalization or ther facility must provide to resident representativ specifies the duration described in paragrap This REQUIREMENT by: Based on staff intervi review, and clinical re determined that the fa bed hold policy notific RR (resident represer	Id notice upon transfer. At a resident for apeutic leave, a nursing of the resident and the rewritten notice which of the bed-hold policy of (d)(1) of this section. Is not met as evidenced lew, facility document cord review, it was acility staff failed to evidence ation to the resident or the intative) prior to or at the time for two of 35 residents in	F	625			
	the facility on 1/28/21. evidence that the resi representative) was p of the bed hold policy transfer. Resident #41 was adr 8/7/2020 with a recen with diagnoses that in to: high blood pressur condition in which her blood vessels of the b and resulting symptor move a body part [as or to speak, paralysis	ransferred/ discharged from The facility staff failed to dent or the RR (resident rovided written notification prior to or at the time of mitted to the facility on t readmission on 2/12/2021, cluded but were not limited e, stroke (abnormal morrhage or blockage of the orain leads to oxygen lack ons - sudden loss of ability to an arm or parts of the face), weakness or if severe, tia (a progressive state of					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(I)	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		495226	B. WING		03	1/12/2021	
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER	730	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW /SVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOW CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(XS) COMPLETION DATE	
F 625	mental decline, especijudgement, often accid(2). The most recent MDS assessment, a quarte assessment reference the resident as scorin interview for mental s resident was moderate cognitive decisions. requiring extensive as member for moving it coded as not moving the lookback period. Devices, the resident wheelchair. A review of Resident sheet revealed that si facility on 1/28/21, and A review of Resident revealed a progress reprogress note stated discharged to a sister (3) diagnosis on 1/28, readmitted on 2/12/2. Further review of Resident RR received any inforbed hold policy. On 3/11/21 at 2:00 p. staff member) #1, the director of nursing, A consultant, and ASM	cially memory function and ompanied by disorientation.) S (minimum data set) orly assessment, with an edate of 2/16/2021, coded g an "8" on the BIMS (brief tatus) score, indicating the tely impalred to make daily. The resident was coded as esistance of one staff in the bed. The resident was in her room or unit during. In Section G0600 - Mobility was coded as using a was discharged from the direadmitted on 2/12/21. #41's clinical record for the dated 2/12/21. The the resident had been a facility due to a COVID-19 (21, and was being a to her home facility. Ident #41's clinical record for the the resident or the remation about the facility's facility is administrator, ASM #2, the SM #3, the clinical	F 625				

	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING				(X3) DATE SURVEY COMPLETED	
		495226	B. WING			03/12/2021		
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		30 LUNENBURG HIGHW			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE		
F 625	follows when a reside facility - even if it is a sister facility - ASM #3 working to "expedite" facility where they we accepting facility as a there were many piece many phone calls invodischarge/transfer promade a packet of infoincluded all of the reg stated, however, that paperwork packet. As holds for them," but coresident or RR was in policy. A review of the facility Transfer," revealed, in transfer to other medionly when medically a the attending physicial transferred or discharnursing home, a copy and referral record an medical information, receiving the resident. No further information. REFERENCES (1) Barron's Dictionar Non-Medical Reader, Chapman, page 114.	bout the process staff int is discharged from a transfer/discharge to a stated the staff was getting residents out of the re and getting to the oon as possible. She stated les of documentation and blived in the locess. ASM #3 stated, "We rmation, which should have ulatory paperwork." She the facility did not retain the SM #1 stated, "We did bed	F	625				

	OF DEFICIENCIES F CORRECTION	(X1) PROV/DER/SUPPLIER/CLIA , IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495226	B. WNG			03/	12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		731	REET ADDRESS, CITY, STATE, ZIP CODE D LUNENBURG HIGHW EYSVILLE, VA 23947		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625	(3) "Coronaviruses ar found in many different including camels, catt of coronavirus identification outbreak of respirator detected in Wuhan, CSARSCoV-2. (Formet 2019-nCoV.) The disc SARS-CoV-2 has been information was obtain https://www.nccih.nih.navirus-and-alternativ 2. Resident #2 was the facility on 1/28/21 evidence that the resi representative) was pof the bed hold policy transfer. Resident #2 was admand was recently read diagnoses that included mentia (a progress especially memory fur accompanied by disorpressure and schizop mental disorders chardistortions of reality, vlanguage, perception (2). The most recent MDS assessment, a signification with an assessment recoded the resident as	e a large family of viruses int species of animals, the, and bats. The new strain ed as the cause of the yillness in people first thina, has been named rily, it was referred to as ease caused by en named COVID-19." This ned from the website: gov/health/in-the-news-coro re-treatments. ansferred/ discharged from The facility staff failed to dent or the RR (resident rovided written notification prior to or at the time of ditted to the facility 5/17/2015 dmitted on 2/23/2021 with ed but were not limited to: live state of mental decline, inction and judgement, often rientation.)(1), high blood hrenia (Any of a group of racterized by gross withdrawal of thought, and emotional response) 6 (minimum data set) cant change assessment, eference date of 3/2/2021, having no difficulty with emory difficulties. The	F	625			

	OF DEFICIENCIES F CORRECTION	(A1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
 		495226	B. WING _		03/12/	/2021
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PROVIDER'S PLAN OF CORRECTIVE PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROFIDENCY)			(X5) COMPLETION DATE
F 625	assistance of one staff bed. Resident #2 req one staff member for In Section G0600 - May was coded as using a A review of Resident a progress note dated stated the resident has sister facility due to a 1/28/21, and was bein her home facility. Further review of Resident has notified of Resident was notified of Resident was notified of Resident was notified of Resident has notified of Resident has notified of Resident has notified of Resident was notified of Resident has notified has notified has not has not has not has not has not has not had not have a sked at follows when a resident facility - even if it is a too had not have not ha	if member for moving in the uired limited assistance of moving in their room or unit. obility Devices, the resident wheelchair. #2's clinical record revealed 2/23/21. The progress note of been discharged to a COVID-19 (3) diagnosis on interesting the control of the search of the stated the staff was getting residents out of the control of the contr	F6	25		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495226	B. WING		03	/12/2021	
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE	
F 625			F	625			
F 641 SS=B	(1) Barron's Dictiona Non-Medical Reader, Chapman, page 124. (2) Barron's Dictionar Non-Medical Reader, Chapman, page 522. (3) "Coronaviruses ar found in many differer including camels, catt of coronavirus identification outbreak of respirator detected in Wuhan, CSARSCOV-2. (Former 2019-nCoV.) The disc SARS-CoV-2 has been information was obtain https://www.nccih.nih.navirus-and-alternativ. Accuracy of Assessm CFR(s): 483.20(g) §483.20(g) Accuracy The assessment must resident's status. This REQUIREMENT by: Based on staff intervand clinical record reverthe facility staff failed MDS (minimum data)	No further information was provided prior to exit. 1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. 2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 522. 3) "Coronaviruses are a large family of viruses bound in many different species of animals, including camels, cattle, and bats. The new strain of coronavirus identified as the cause of the nutbreak of respiratory illness in people first detected in Wuhan, China, has been named SARSCOV-2. (Formerly, it was referred to as 2019-nCoV.) The disease caused by SARS-CoV-2 has been named COVID-19." This information was obtained from the website: https://www.nccih.nih.gov/health/in-the-news-coronavirus-and-alternative-treatments (CCUTA) Assessments CFR(s): 483.20(g) 483.20(g) Accuracy of Assessments. The assessment must accurately reflect the esident's status. This REQUIREMENT is not met as evidenced		F 641 Resident # 7 care plan co corrected by the MDS Coordinator 100% audit of Residents I Data Set Assessments were audite MDS Coordinator and Facility Consaccuracy of Section "O" on 3/17/21 negative findings. In-service on MDS for accoding rules as per the RAI manua Section "O" completed on 3/17/21 of Health Services. The MDS Coordevelop a comprehensive care plandialysis resident and complete Sec Special treatments for dialysis. This completed with the initial assessment updated as needed.	on 3/11/21. Inimum d by the ultant for with no uracy per to include y the VP linator will for the ion "O" will be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATÉ SURVEY COMPLETED		
		495226	B. WNG			03/	12/2021
	ROVIDER OR SUPPLIER D NURSING AND REHAB	ILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(X5) COMPLETION DATE
F 641	procedures and progra a quarterly assessment reference (assessment reference the resident as "No" if The findings include: Resident #7 was adm 6/12/20. Resident #7 were not limited to: (inability of the kidney function in the mainte (1), mental disorder (a such as disturbance of emotional equilibrium blood pressure) (3). Resident #7's most reassessment with an Adate) of 12/15/20, code scoring a of 07 out of interview for mental s resident is severely in review of the MDS Seconded the resident as bed mobility, locomotide dependence for hygic Section H- bowel and coded as always incombadder function. A recoded the resident as resident. A review of the nursin 12/15/20 at 3:45 AM, "Resident out of facility scheduled dialysis. In	rams of Resident #7's MDS, and with an ARD be date) of 12/15/20, coded or dialysis while a resident. Initial to the facility on the diagnoses included but and stage renal disease are to excrete wastes and mance of electrolyte balance any disorder of the mind of perceptions, memory and the diagnoses and diagnoses and diagnoses and diagnoses and programs and	F	541	The DON or designee will rev MDS assessments for new resident admissions to ensure Section "O" is co accurately for Special Treatments one-weekly x 4 weeks during the Cardinal I meeting. The DON or designee will immediately notify the MDS coordinator identified areas of concerns for correct Retraining with the MDS Coordinator with provided as needed. The Director of Nursing and/ordesignee will submit the audit findings MDS accuracy per coding rules as per manual monthly to the QAPI Committee month.	mpleted time DT r of all ion. rill be or for the RAI	04/12/21

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495226	B, WING			03/12/2021		
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		·		
(X4) ID PREFIX TAG			1	ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP			(X5) COMPLETION DATE	
F 641	12/15/20 at 9:45 AM, "Resident returned to patient transport. No An interview was come PM with RN (registere coordinator, regarding assessment. RN #2 sereflect the resident's sereflect the resident the sereflect the sereflect the sereflect the sereflect the resident the sereflect the ser	g progress notes dated documented in part, facility from dialysis via acute distress noted". ducted on 3/10/21 at 1:44 ed nurse) #2, the MDS g the purpose of the MDS stated, "The MDS should status. As long as an item occurred in the previous 90 ecked on the quarterly MDS eask to review Resident #7's 12/15/20 Section O, RN #2 erked no. That is incorrect stently received dialysis note he has been here". M, RN#2 stated, "I corrected the MDS Section O for that 17']". PM, ASM (administrative ministrator), #2 (director of director), #4 (regional 45 (director of nursing for	F	641				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIËR/CLIA IDENTIFICATION NUMBER:	146.50	IPLE CONSTRUCTION	(X3) DATE COMP	SURVEY
		495226	B. WING		03/	12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIE!	OTION SHOULD BE OTHE APPROPRIATE	(X5) COMPLETION DATE
F 641 F 656 SS≃D	(3) Barron Dictionary edition, Rothenberg a Develop/Implement CCFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The faci implement a comprehe care plan for each resident rights set for §483.10(c)(3), that into objectives and timeframedical, nursing, and needs that are identificant assessment. The condescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the runder §483.10, including the physical as a result of recommendations. If findings of the PASAI rationale in the reside (iv) In consultation wit resident's representa (A) The resident's prefuture discharge. Factorial in the resident's prefuture discharge.	cf Medical Terms, 7th and Kaplan, page 282. Comprehensive Care Plan cersive Care Plans cility must develop and tensive person-centered sident, consistent with the that §483.10(c)(2) and cludes measurable arms to meet a resident's mental and psychosocial fied in the comprehensive care plan must personal mental and psychosocial fied in the comprehensive psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not estident's exercise of rights ding the right to refuse 3.10(c)(6). The resident of the psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not estident's exercise of rights ding the right to refuse 3.10(c)(6). The resident of the psychosocial will passage as a facility disagrees with the RR, it must indicate its ent's medical record. The resident and the		reviewed and update by Nursing (DON) on 3/11/2 interventions for post-ope • An audit of care admitted post-operatively MDS Consultant on 3/26 care plan for resident #95 centered comprehensive been developed based u assessment of resident in preferences, and preadmines address the resident review. The care by MDS Consultant on 3/26 identified areas of conceinglans address the reside include interventions for applicable. • The Minimum Dictionary Coordinator, Social Work Activity Director, and lice educated by the DON and 4/8/21 on the need to encomprehensive care plar and based upon physicial assessment of the reside preferences, and preadminclude interventions for applicable.	entive care. plans for residents was conducted by 6/21, to include the 9, to ensure resident- care plans have pon physician orders, needs and nission screening, and a plans were updated //26/21 for any rn to ensure the care nts' current status, to post-operative care as eata Set (MDS) ker, Dietary Manager, nsed nurses will be nd MDS Consultant by sure that the n is resident-centered an orders, the ent's needs and nission screening and post-operative care as signee will review all nents for subsequent to ensure the care dent status, to include erative care, by ers, discharge on screenings,	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	B. WING			03/12/2021	
	ROVIDER OR SUPPLIER NURSING AND REHAB		r	73	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREF	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 656	local contact agencies entities, for this purpo (C) Discharge plans is plan, as appropriate, requirements set forth section. This REQUIREMENT by: Based on staff intervirely and clinical red determined the facility or implement the component of thirty five resident #99. The fact and implement a compaddress post-operative. The findings include: Resident #99 was add 3/4/21 with diagnoses limited to: right total k replacement of knee j diabetes mellitus (inal normally in the body) blood pressure) (3). The most recent MDS assessment, a Medical (assessment reference the resident as scoring BIMS (brief interview indicating the resident as bed mobility, hygiene,	seed and any referrals to a and/or other appropriate se. In the comprehensive care in accordance with the in paragraph (c) of this is not met as evidenced sews, facility document cord review, it was a staff failed to develop and / prehensive care plan for ents in the survey sample, cility staff failed to develop prehensive care plan to be care for Resident #99. In that included but were not the replacement (surgical coint with a prosthetic) (1), collity of insulin to function (2) and hypertension (high series 5 day with an ARD see date) of 3/10/21, coded grants at the survey intact. A section G-functional status requiring supervision for	F		assessments x 4 weeks utilizing a care plaudit tool. The DON or designee will immupdate the care plan for all identified are concerns and provide retraining with the identified staff member. The results of the care plan aud will be compiled by the administrator or deand presented to the Quality Improvement Committee monthly x 1 month. Identification will determine the need for further and/or change in frequency of required monitoring. Completion Date: 4/12/21	ediately as of it tool esignee nt tion of	04/12/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X3) DATE SURVEY COMPLETED	
	495226	B. WING_		03/1	2/2021
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABIL	LITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
PREFIX (EACH DEFICIENCY			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
Section H- bowel and be as always continent for a review of Resident #4 dated 3/4/21, document Primary diagnosis, Clin replacement, Description in replacement, Description in replacement surged #99's nursing admission documented in part, "Rescar". Review of nursing 3/4/21 at 12:10 PM, do "Dressing covering postlean, dry and intact". A review of the compresed depost-operative care for interview was conducted with LPN (licensed praced participation of the purpose of plan. LPN #1 stated, "I the resident." When as for a resident who is postfarmater, signs and sympain control". An interview was conducted purpose of the compresed purpose of t	in eating. A review of MDS bladder coded the resident in bowel and bladder. 199's medical diagnosis inted in part, "Rank: inical Category: major joint on: aftercare following ery". A review of Resident on evaluation dated 3/4/21, tight knee post surgical ing progress note dated ocumented in part, est surgical site (right knee) 10 chensive care plan failed to ocumentation of Resident #99. An ead on 3/10/21 at 1:41 PM octical nurse) #1. When of the comprehensive care plan for the comprehensive care plan ost knee replacement, LPN exit to see how they inpromise of infections and interventions". When the care of the residents in the care of the residents in the care plan for N#1 stated, "The care plan in the care plan for N#1 stated, "The care plan in the care plan in the care plan in the care plan in the care plan for N#1 stated, "The care plan in the care plan i	F	356		

PRINTED: 03/17/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	B. WING			03/	12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	· · · · · · · · · · · · · · · · · · ·	
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F 656	On 3/10/21 at 4:30 PM member) #1, the adm director or nursing and consultant were inform. The comprehensive c was revised on 3/11/2 care plan revealed in At risk for infection relipost right total kneers. Treatments as orderer resident to drink sufficing signs/symptoms of inference to the comprehension of community and the comprehension.	MASM (administrative staff inistrator, ASM #2, the d ASM #3 the nurse ned of the above concerns. are plan for Resident #99 11. Review of the revised part the following: "Focus: ated to surgical site status aplacement. Interventions: d by physician, encourage cient fluids and observe for ection to include increased	F	656			
F 657	Plan" dated 11/13/17, the policy of the facility resident-centered care physician's orders, the resident's needs and a pre-admission screening No further information. References: 1. Barron Dictionary of edition, Rothenberg and 2. Barron Dictionary of edition, Rothenberg and 3. Barron Dictionary of edition, Rothenberg and delition, Rothenberg and edition, Rothenberg and edition.	e plan based upon e assessment of the preferences, and ing and resident review. was provided prior to exit. f Medical Terms, 7th and Kaplan, page 319. f Medical Terms, 7th and Kaplan, page 160. f Medical Terms, 7th and Kaplan, page 282.	F	657		2	
		Revision	F	657			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
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F 657	be- (i) Developed within 7 the comprehensive as (ii) Prepared by an int includes but is not tim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent prace the resident and the r An explanation must is medical record if the g and their resident rep- not practicable for the resident's care plan. (F) Other appropriate disciplines as determi- or as requested by th- (iii) Reviewed and revi- team after each asses comprehensive and q assessments. This REQUIREMENT by: Based on resident int review, staff interview review it was determi- residents in the surve Resident #33 returned on 1/8/21 with a splint	ensive Care Plans brehensive care plan must days after completion of sessment. erdisciplinary team, that ited to sician. with responsibility for the responsibility for the and nutrition services staff. ticable, the participation of esident's representative(s). be included in a resident's carticipation of the resident resentative is determined development of the staff or professionals in nad by the resident's needs a resident. sed by the interdisciplinary esment, including both the uarterly review is not met as evidenced derview, clinical record and facility document ned facility staff failed to sive care plan for one of 35 y sample, Resident #33. d from the emergency room is (immobilizer) in place to weight bearing status, which	F6	F 657 The care plan for resident #33 reviewed and updated by the MDS coon 3/11/21 to reflect weight bearing sta splint care, recommended monitoring for compartment syndrome, checking dorse pedis pulses, and elevating right lower extremity when out of bed in chair. An audit of all comprehensive plans was conducted for residents who transferred to the emergency room or he consultation visit in the past 60 days, in the care plan for resident #33 by MDS. Consultant on 3/26/21 to ensure the comprehensive care plan was updated reflect new conditions and/or new recommendations for care. Care plans updated as needed to ensure the comprehensive care plan included proving recommendations and reflect resident's status by MDS Consultant on 3/23/21. The Minimum Data Set (MDS) Coordinator, Social Worker, Dietary Ma and licensed nurses were educated on planning requirements and need to immediately update a resident's care preflect current status and recommendate made by providers by DON and MDS Consultant by 4/8/21. Upon a resident's return from emergency room or consultation visit, to licensed floor nurse will review accompany progress notes and/or provider instruct update the resident care plan according reflect any new provider recommendations resident's current status. A follow up rewill be conducted by the Director of Nu (DON) and MDS Coordinator during da Cardinal IDT Meetings, Monday-Friday weeks to ensure the resident's care plan appropriately updated to reflect new process of the provider of the recommendations and resident status to recommendations and resident status to the recommendations and resident status.	rdinator tus, or alis care were ad a cluding to were der current care an to anions the he anying ions and gly to ons and eview rsing ily , x 8 in was ovider	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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0	ROVIDER OR SUPPLIER D NURSING AND REHAB	ILITATION CENTER	7	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW (EYSVILLE, VA 23947		
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F 657	diagnoses that includ cerebral infarction (1) hemiparesis (3) affectivitamin D deficiency (1) Resident #33's most set), a quarterly asset (assessment reference Resident #33 as scort assessment for ments of 0 - 15, 15- being or daily decisions. Sections as requiring extensive for transfers and exterperson for personal his Section J coded Resident #33 was obwith major injury. On 3/9/21 at approximiterview was conducted that section when the Cassistant was assistive wheelchair. Resident #33 shathroom when the Cassistant was assistive wheelchair. Resident sure if the wheelchair on her and she fell to stated that she went to next day after an x-raseeing a specialist above.	mitted to the facility with ed but were not limited to hemiplegia (2), ting right dominant side, and (4). Trecent MDS (minimum data assment with an ARD see date) of 2/20/2021, coded ing a 15 on the staff all status (BIMS) of a score or	F 657	a care plan audit tool. The DO Nurse will immediately update all identified areas of concerns designee will provide retraining identified staff member. The results of the care will be compiled by the administ designee and presented to the Improvement Committee month Identification of trends will dete for further action and/or change required monitoring.	the care plan for and the DON or with the e plan audit tool strator or Quality nly x 2 months.	04/12/21

NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER (XA) 10 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR 1.5.2 IDENTIFYING INFORMATION) F 657 Continued From page 50 Resident #33 documented in part, - "Check Dorsalls Pedel (sic) pulse (pulse in foot) BID (twice a day) (fight leg FX (fracture))." - "NWB (non-weight bearing) RLE (right lower extremity) x 8 weeks (for eight weeks). Dx (diagnosis) Right thin/fib (tibia/fibuis) (long bones in the lower leg) FX. FYI." The progress notes for Resident #33 documented in part, - "177/2021 15:32 (3:32 p.m.) Late Entry: Note Text: On 17721, resident was assisted to her wheelchair. MD (medical doctor) made aware with note in communication log, Resident is her own RR (resident representative)." -"1/8/2021 11:24 (11:24 a.m.) Late Entry: Note Text: called to room by CNA (certified nursing assistant) stating residunt is crying and complaining of right lag hurting. Writer entered room and resident in bed, when writer sitempted to straighten leg in bed to assess it resident grimacing and drying that it hurt. Resident explained that when she fell yesterday that her leg went behind her. On assessment, swelling noted to right lower extremily mid shin. Resident able to pelpate pulses proximal and distally to pain point of the Method without difficulty. Writer able to pelpate pulses proximal and distally to pain point of the Method without difficulty. Writer able to pelpate pulses proximal and distally to pain point of the Method without difficulty. Writer able to pelpate pulses proximal and distally to pain		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
MAYLAND NURSING AND REHABILITATION CENTER (A) 10 (A) 10 (A) 10 (B) 10 (495226	B. WING_		03/	12/2021
PRÉFIX TAG REGULATORY OR LS.3 DEPTIFYING INFORMATION) F 657 Continued From page 50 Resident #33 documented in part, - "Check Dorsalis Pedel [sic] pulse (pulse in foot) BID (twice a day) (Right leg FX (fracture))." - "Continue Cadalac splint. FYI (for your information)." - "NWB (non- weight bearing) RLE (right lower extremity) x 8 weeks (for eight weeks). Dx (diagnosis) Right lib/fib (tibia/fibula) (long bones in the lower leg) FX. FYI." The progress notes for Resident #33 documented in part, - "1/7/2021 15:32 (3:32 p.m.) Late Entry: Note Text: On 1/7/21, resident was assisted to her knee while attempting to transfer to her wheelchair. MD (medical doctor) made aware with note in communication log. Resident is her own RR (resident representative)." -"1/8/2021 11:24 (11:24 a.m.) Late Entry: Note Text: called to room by CNA (certified nursing assistant) stating resident is crying and complaining of right leg hurting. Writer entered room and resident in bed, when writer attempted to straighten leg in bed to assess it resident grimacing and crying that it hurt. Resident explained that when she fell yesterday that her leg went behind her. On assessment, swelling noted to right lower extremity mid shin to foot, area of pain beginning mid shin. Resident able to flex and retract foot without difficulty. Writer able to pelpate pulses proximal and distally to pain			ILITATION CENTER		730 LUNENBURG HIGHW		8.
Resident #33 documented in part, - "Check Dorsalis Pedel (sic) pulse (pulse in foot) BID (twice a day) (Right leg FX (fracture))." - "Conlinue Cadalac splint. FYI (for your information)." - "NWB (non- weight bearing) RLE (right lower extremity) x 8 weeks (for eight weeks). Dx (diagnosis) Right tib/fib (tibla/fibula) (long bones in the lower leg) FX. FYI." The progress notes for Resident #33 documented in part, - "1/7/2021 15:32 (3:32 p.m.) Late Entry: Note Text: On 1/7/21, resident was assisted to her knee while attempting to transfer to her wheelchair. MD (medical doctor) made aware with note in communication log. Resident is her own RR (resident representative)." -"1/8/2021 11:24 (11:24 a.m.) Late Entry: Note Text: called to room by CNA (certified nursing assistant) stating resident is crying and complaining of right leg hurting. Writer entered room and resident in bed, when writer attempted to straighten leg in bed to assess it resident grimacing and crying that it hurt. Resident explained that when she fell yesterday that her leg went behind her. On assessment, swelling noted to right lower extremily mld shin to foot, area of pain beginning mid shin. Resident able to flex and retract foot without difficulty. Writer able to palpate pulses proximal and distally to pain	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
update her on findings and to request xray of tib/fib (tibia/fibula). Telephone order received and passed to floor nurse, [Name of nurse], LPN (licensed practical nurse). Resident is her own RR [resident representative]."		Resident #33 docume - "Check Dorsalis Ped BID (twice a day) (Rig - "Continue Cadalac s information)." - "NWB (non- weight the extremity) x 8 weeks ((diagnosis) Right tib/fil in the lower leg) FX. If The progress notes for in part, - "1/7/2021 15:32 (3:3) Text: On 1/7/21, reside knee while attempting wheelchair. MD (medi with note in communic own RR (resident repr -"1/8/2021 11:24 (11:2) Text: called to room by assistant) stating resid complaining of right lef room and resident in be grimacing and crying the explained that when silled went behind her. On noted to right lower ex area of pain beginning flex and retract foot with to palpate pulses prox point of shin. Writer ca update her on findings tib/fib (tibia/fibula). Tele passed to floor nurse, (licensed practical nurse,	anted in part, lel [sic] pulse (pulse in foot) whit leg FX (fracture))." splint. FYI (for your pearing) RLE (right lower for eight weeks). Dx b (tibia/fibula) (long bones FYI." In Resident #33 documented 2 p.m.) Late Entry: Note ent was assisted to her to transfer to her cal doctor) made aware cation log. Resident is her resentative)." 4 a.m.) Late Entry: Note y CNA (certified nursing lent is crying and g hurting. Writer entered and to assess it resident that it hurt. Resident the fell yesterday that her on assessment, swelling tremity mid shin to foot, mid shin. Resident able to thout difficulty. Writer able imal and distally to pain alled MD (medical doctor) to and to request xray of ephone order received and [Name of nurse], LPN se). Resident is her own	F6	57		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		1, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495226	B. WING	<u> </u>		03/12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAL	BILITATION CENTER		STREET ADDRESS, CITY, STATE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
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F 657	Text: Writer went to be entering room reside propelling self in room states pain is a little should be coming to understanding." - "1/8/2021 22:09 (10 results of right lower fibula and distal tibiat to ER (emergency room [Name of hosping [Room number]. Resource of the practitioner], NP call done results Fracture ankle. Resident to be leg. Long splint to Rt (orthopedic] consults for compartment syn spouse] made awares - "2/9/2021 10:41 (10 plan meeting held. Resident to be self the synthesis of	31 p.m.) Late Entry: Note reassess resident, upon ent up in wc (wheelchair) m, swelling remains and she better. Informed her that they do the xray, she verbalized 2:09 p.m.) Note Text: Xray leg: fracture of proximal and she better. Advised nurse to sent [sic] from) for further treatment." 15 p.m.) Note Text: Return that they have an alert. place and situation. Long g. [Name of nurse and reported x-ray of leg for x 2 at tib/fib knee and rt. In leg do not remove. Ortho has soon as possible. Monitor drome (5). Spouse [Name of the xident and resident. Resident such as a FULL CODE. Resident thing and sleeping good. It is a FULL CODE. Resident thing and sleeping good. It is generally a such as the xident and sleeping good. It is generally a such as a cute fractures of the	F	657		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER NURSING AND REHAE	BIRTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP (730 LUNENBURG HIGHW KEYSVILLE, VA 23947	ODE	00/16/2021	
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	33, dated 1/8/2021 doPatient received a factorization and splint fractures. It is recome home was notified the benon-weightbearing orthopedics as soon at the orthopedic "Report Resident #33, dated part,"Recommend splint that she already dry. No weight bearing extremity] x 8-12 wee weeks). Tylenol as mustates this helps most (dorsalis pedis) pulse sit in wc (wheelchair) (right) one elevated The orthopedic "Report Resident #33, dated part,"Continue splinkeep clean and dry RLE 4-8 more weeks The fall investigation of 1/7/2021 documented description: Called to (certified nursing assistant) Called to (certified nursing assistant) called the control of con	cumentation" for Resident ocumented in part, " full posterior splint with ankle ning based on the above mended and the nursing at the patient would need to g along with referral to as possible" ort of Consultation" for 1/18/2021 documented in ations: Continue Cadalac y has on. Keep clean and not RLE [right lower edded for pain- pt (patient) to f the time. Check DP BID (twice a day). Pt may v. Ith B (both) leg rests, R." ort of Consultation" for 2/4/2021 documented in int for 4 (four) more weeks, NWB (non-weightbearing)" for Resident #33, dated in part, "Nursing president's room by CNA stant) to assist with resident. eeling in front of her proom. Resident and it slid knee." No injuries	F	657			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA , IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	/DE		
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F 657	and began to let hers to keep her from fallir residents feet, so she floor to her knees. Si under her" The fall an incident report dat statements dated 1/9 summary dated "1/7/5 falls)." The comprehensive of Resident #33 docume characterized by multimpaired balance, impafety awareness, fall (2/11/21 & 2/27/21). If Revision on: 02/28/20 it documented in part negotiate barriers as 01/11/2021" The odocumentation regard place after Resident allower leg. On 3/11/21 at approxinterview was conductive was conducted in the morn that daily care plan up the interdisciplinary to them quarterly. RN # resident had a fall an and an intervention was prevent a reoccurrence stated that she did no regarding the non-weight and the state of the state of the regarding the non-weight and the regarding the resident that she did not regarding the non-weight and the resident the resident that she did not regarding the non-weight and resident the resident that she did not regarding the non-weight and resident the resident that she did not regarding the non-weight and resident the resident that she did not regarding the non-weight resident that she did not regarding the non-wei	elf down, CNA was not able ing, due to the position of a assisted resident to the tates her legs were crossed it investigation documented ed 1/7/2021, witness //21 and an investigational 21-2/27/21 (due to continued 21-		657			

NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 657 Continued From page 54 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947 (X5) (EACH CORRECTION (EACH CORRECTION ACTION SHOULD BE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) F 657 Continued From page 54 F 657	STATEMENT OF DEFIC AND PLAN OF CORRE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DATE) CROSS-REFERENCED TO THE APPROPRIATE DATE			495226	B. WING_		03	/12/2021	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			BILITATION CENTER		730 LUNENBURG HIGHW			
F 657 Continued From page 54 F 657	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI)	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETION	
that the splint immobilizer should have been addressed on the care plan. On 3/11/21 at approximately 11:44 a.m., an interview was conducted with LPN (licensed practical nurse) #2, regarding purpose of the comprehensive care plan. LPN #2 stated that the care plan was for staff to know what to do for the specific resident. LPN #2 stated that the care plan also contained a care guide, which helped the CNA (certified nursing assistant) know how to care for the resident. LPN #2 stated that care plans were updated or revised when there was a change in condition. LPN #2 stated that when a resident had a fall the care plan was reviewed and they would add any, interventions put into place. LPN #2 stated that when a resident had any fall with injury, or a new weight bearing status they would update the care plan to reflect it. LPN #2 stated that when residents return to the facility from the emergency room the documentation was reviewed and the orders and care plan were updated. LPN #2 stated that any nurse could update the care plan. A review of the facility policy, "Resident Care Plan" dated "Revision 11/13/2017" documented, "It is the policy of the facility to provide a written resident-centered care plan based upon physician's orders, the assessment of the resident needs and preferences, and pre-admissions screening and resident review (PASRR)" The policy further documented. "The resident care plan will be an ongoing process and will include current problems and/or needs identified from a complete assessment" On 3/11/21 at approximately 2:00 p.m., ASM (administrative staff member) #1, the	that the address on 3/ intervented for the Court of plans of the Court of plans of the Court of plans of the year	hat the splint immobile addressed on the care of addressed on the care of a specific resident. Let of a specific resident a specific resident a specific resident a specific resident when resident and the ord application. A review of the facility resident and possible the care plan. A review of the facility resident reeds and possible resident reeds and possible resident reeds and possible resident care plantations. The pol The resident care plantations are plantations and will include the care of a specific resident reeds and possible resident care plantations. The pol The resident care plantations are plantations and possible resident care plantations. The pol The resident care plantations and possible resident care plantations. The pol The resident care plantations are plantations.	initizer should have been be plan. innately 11:44 a.m., an exted with LPN (licensed begarding purpose of the plan. LPN #2 stated that the fif to know what to do for the N #2 stated that the care a care guide, which helped raing assistant) know how to LPN #2 stated that care or revised when there was a LPN #2 stated that when a care plan was reviewed any interventions put into it that when a resident had a new weight bearing status are care plan to reflect it. LPN residents return to the facility from the documentation was ers and care plan were set and care plan were set that any nurse could be plan based upon a sessessment of the references, and an ining and resident review it for the plan based upon a complete assessment"	FE	557			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495226	B. WING			03/	12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 00 LUNENBURG HIGHW EYSVILLE, VA 23947		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	ASM #3, the regional aware of the above of No further information References: 1. Cerebrovascular daccident is a stroke. The brain stops. A strown attack." If blood than a few seconds, the nutrients and oxygen lasting damage. This from the website: https://medlineplus.go. 2. Hemiparesis - Parfunction in part of you obtained from the well https://medlineplus.go. 3. Hemiplegia- also operaplegia, Quadriple muscle function in pawhen something goes messages pass between paralysis can be comon one or both sides occur in just one area This information was https://medlineplus.go. 4. Vitamin D deficient	2, the director of nursing and vice president were made oncern. It was presented prior to exit. It is ease, infarction or When blood flow to a part of oke is sometimes called a diflow is cut off for longer the brain cannot get Thrain cells can die, causing information was obtained ov/ency/article/000726.htm. It alysis is the loss of muscle or body. This information was obtained ov/paralysis.html. It called: Hemiplegia, Palsy, and Paralysis is the loss of ort of your body. It happens is wrong with the way een your brain and muscles. plete or partial. It can occur of your body. It can also on, or it can be widespread. Obtained from the website: ov/paralysis.html.	E.	657			

	OF DEFICIENCIES F CORRECTION	(C1) PROVIDER/SUPPLIER/CLIA , IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	(X3) DATE COMP	SURVEY
		495226	B. WING		03/	12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695 SS=D	syndrome is a serious increased pressure in can lead to muscle ar problems with blood f obtained from the well https://medlineplus.go Respiratory/Tracheos CFR(s): 483.25(i) § 483.25(i) Respirator tracheostomy care and The facility must ensure and tracheal succare, consistent with practice, the compreherand 483.65 of this sull This REQUIREMENT by: Based on staff interviand clinical record reviand dinical record reviand staff failed to promistent with professor two of thirty five resample, Resident #47 1. The facility staff failed to promistent with professor two of thirty five resample, Resident #47 2. The facility staff failed to promise the sample of the sample	drome- Acute compartment is condition that involves a muscle compartment. It ind nerve damage and low. This information was obite: ov/ency/article/001224.htm tomy Care and Suctioning detracheal suctioning. It is that a resident who is including tracheostomy tioning, is provided such professional standards of pensive person-centered its goals and preferences, opart. It is not met as evidenced liew, facility document review view, it was determined the rovide respiratory care sidents in the survey and Resident #24. Itel administered oxygen to a physician order for lied to provide respiratory manner for Resident #24. Itel an ebulizer (1) mask and other (2) uncovered on the	F 65	F 695-	as ag sever solastic de. Interpretation der sector of size and areas of by the sever sines by reder with the annula or apy and ing must at the sissions Audit order the order th	
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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		495226	B. WING			03/12/2021	
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695	The findings include: 1. Resident #47 was 12/4/19 with diagnose limited to: chronic obs [COPD] (non-reversib syncope (brief loss of temporary insufficient (2) and atrial fibrillatio contraction of atria of The most recent MDS assessment, an annu (assessment reference the resident as scoring BIMS (brief interview indicating the resident as bed mobility, transfer, walking. Resident is it dressing and bathing. He-bowel and bladder always continent for b O-oxygen therapy where. On 3/9/21 at 3:25 PM, 3/10/21 at 2:10 PM., continent for price in the second of the property of the property of the second of the property of the pr	admitted to the facility on as that included but were not structive pulmonary disease le lung disease) (1), consciousness due to flow of blood to the brain) in (rapid and random the heart) (3). If (minimum data set) all assessment with an ARD edate) of 2/10/21, coded go a 15 out of 15 on the for mental status) score, it is cognitively intact. A ction G-functional status requiring supervision for hygiene, eating and independent in locomotion, A review of MDS Section coded the resident as owel and bladder. Section ille a resident was coded as dent was receiving oxygen.	F	695	and obtain the order and implement. Residents using suction catheters and Nebulizer tubing will be provided with bag for storage at bedside upon admise. The DON or designee will au oxygen dependent residents for physicorders and residents using suction cathe and nebulizer tubing for proper storag weekly x 4 weeks. The audits will be rin the Cardinal IDT meetings and any identified of concern will be corrected Director of Nursing and the MD. The findings of the Audits for suction catheters and nebulizer tubing reviewed during the monthly QAPI corx 1 month.	a plastic ssion. dit cian heters e eviewed areas by the oxygen, will be	04/12/21
i b	concentrator that was meter was observed s A review of the physic	running. The oxygen flow et at 3 liters. ian orders for Resident #47 falled to evidence physician					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495226	B. WNG_		03	3/12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(XS) COMPLETION DATE
F 695	Review of Resident # dated 2/4/21 at 9:27 F "Special treatments: minute continuous". Review of Resident # dated, 3/9/21 at 3:17 "Respiratory- oxygen of the respiratory care #47 dated 3/9/21 at 1 "Oxygen vial nasal ca 97%. Rate of oxygen A review of the compressident #47 dated 1 "Focus: Potential for breathing pattern rela costructive pulmonary respiratory failure. Interapy as ordered." An interview was conc PM with LPN (license regarding Resident #47] has be	47's nursing admission PM, documented in part, Oxygen therapy- 3 liters per 47's nursing progress note PM, documented in part, via nasal cannula". A review of evaluation for Resident GO AM, documented in part, nnula, oxygen saturation 3 liters per minute." The hensive care plan for 2/4/19 documented in part, or actual ineffective ted to COPD (chronic or disease) with emphysema, terventions: Oxygen ducted on 3/10/21 at 1:41 dd practical nurse) #1 17. LPN #1 stated, "She	F6	,		
	An interview was cone PM with RN #1, regar administration of oxyg (Resident #47) has be her paperwork. I will h transferred from, as the paper chart, so I cannoxygen she is on". RI	N #1 was then observed I then stated, "There isn't an				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495226	B. WING_			03/12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAE	SILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	CODE	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BI THE APPROPRIA	
F 695	#47 gets shortness o walking to the bathrotwo liters per minute. the physician to order give us parameters for On 3/10/21 at 2:20 Plot Resident #47's root observed receiving or connected to the condition of the	M, RN #1 stated, "Resident for breath with exertion and om but at rest is tolerating. I will leave a message for rothe oxygen, maybe she can be two liters or three liters." M, RN #1 was accompanied on. Resident #47 was exygen via nasal cannula centrator that was running, ident #47's oxygen ter that was set at three this time Resident #47 was exided if she changed the lent #47 stated, "Oh, I never then observed adjusting the ers per minute. M RN #1 presented a desident #47 that oxygen two liters to three ers of breath and shortness on". M ASM (administrative staff inistrator, ASM #2, the d ASM #3 the nurse med of the above concerns. At the facility policy and stywas made for a policy for enting orders. No policy	F	595		
	No further information References:	was provided prior to exit.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI			(X3) DATE SURVEY COMPLETED		
		495226	B. WING				03/12/2021	
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		730 L	ET ADDRESS, CITY, STATE, ZIP CODE UNENBURG HIGHW SVILLE, VA 23947		V0118/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF: TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 695	2. Barron Dictionary of edition, Rothenberg at 3. Barron Dictionary of edition, Rothenberg at 2. The facility staff far services in a sanitary. The facility staff store a yankauer suction can ightstand in Resident Resident #24 was addiagnoses that include chronic obstructive puranemia (4). Resident #24's most reset, a quarterly asses (assessment reference Resident #24 as scori assessment for menta of 0 - 15, 9- being mormaking daily decision Resident #24 receiving the facility. On 3/9/21 at approximate interview was attempted their room. Observation revealed a suction manightstand to the left of suction was observed machine and was obsinghtstand uncovered observed touching the A nebulizer machine with a nebulizer machine with a nebulizer machine with a nebulizer machine and with a nebulizer machine and with a nebulizer machine with a nebulizer machine with a nebulizer machine and with a nebulizer machine and with a nebulizer machine with a nebulizer machi	of Medical Terms, 7th and Kaplan, page 120. of Medical Terms, 7th and Kaplan, page 551. of Medical Terms, 7th and Kaplan, page 54. of Medical Terms, 7th and Kaplan, page 54. of Medical Terms, 7th and Kaplan, page 54. of Applan, page 54. of Medical Terms, 7th and the Applan of Applan, page 55. of Medical Terms, 7th and the Applan of Applan, page 55. of Medical Terms, 7th and the Applan of Applan, page 54. of Medical Terms, 7th and the Applan of Applan, page 54. of Medical Terms, 7th and the Applan of Applan, page 55. of Medical Terms, 7th and the Applan of Applan, page 54. of Medical Terms, 7th and the Applan of Applan, page 54. of Medical Terms, 7th and the Applan of Applan, page 54. of Medical Terms, 7th and the Applan of Applan, page 54. of Medical Terms, 7th and the Applan of Applan, page 54. of Medical Terms, 7th and the Applan of Applan of Medical Terms, 7th and the Applan of Medical Terms, 7th and the Applan of Medical Terms, 7th and Medical Terms, 7th an	F	695				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	B, WING			03/	12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAE	ILITATION CENTER		730	REET ADDRESS, CITY, STATE, ZIP CODE 0 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
F 695	lying on the nightstan machine and the night asked if the staff used nebulizer, Resident # Additional observation on 3/9/21 at 2:20 p.m above. Observations 3/10/21 at 9:00 a.m. a revealed the findings The physician's order Resident #24 docume - "Duoneb Ipratropium premixed unit via neb needed for wheezing "Suction PRN (as new 12/1/21-2/28/21 documented in part," documented Residen (three times) on 2/1/2 The progress notes for in part the following: - "2/23/2021 06:45 (6:0) Resident presenting with the following suctioned x 3 (three tof thick clear sputum. greatly decreased. Prapplied for 15 minutes quietly at this time. Sp @2L/NC (at two liters no cyanosis (bluish diese to suction of the staff of the staf	vas observed uncovered and did touching the suction instand table surface. When did the suction and the 24 nodded in confirmation. Ins of Resident #24's room on and 3/10/21 at 11:45 a.m. above. Is dated 3/1/21-3/31/21 for ented in part, in/Sol (solution) Albuterol 1 invitive every four hours as 02/21/19." In administration record) for Resident #24 Suction prn." The MAR at #24 being suctioned "X3" 1. In the resident #24 documented in the surface of	F	695			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495226	B. WING _		03	/12/2021	
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		LD BE	(X5) COMPLETION DATE	
F 695	LEGACY CARE PRO NOTE; Federally many visit, based on the restor evaluation of chronic current status. [Resident #24] long chronic obstructive punonproductive cough rest. He requires conticannula for his activiti. He denies any wheez with inspiration (inhali.) The comprehensive codated 2/2/2021 documents for fluid output characterized [sic] by the and mucous membrane integrity related to: alto uncontrolled health continuous membrane; the declining health conditioned in the continuous membrane; the declining bate Initiation suctioning Date Initiations.	VIDER RECERTIFICATION Idated required provider Sident's date of admission, nic medical conditions and Ient #24] is an [Age and Sex Ierm care resident who has Ilmonary disease. He has a and shortness of breath at inuous oxygen via nasal es of daily living and sleep. ing, orthopnea (5) or pain ng)." are plan for Resident #24 nented in part, exceeding intake fluid volume deficit; dry skin nes, poor skin turgor and ered intake process, anditions Date Initiated: care deficit pertaining to the aracterized by; altered oral eeth/gums related to: tion, medication, oxygen, , need for occasional ed: 12/13/2019." al Ineffective Breathing nitiated: 03/12/2019	Fe	695			
	administration, LPN # was stored in a plastic #3 stated that the purp to keep it clean and from				÷.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	2 LOW MEDICANE &	MEDICAID SERVICES				CIMP MC	1 0020-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A BUILD		(X3) DATE SURVEY COMPLETED		
		495228	B. WING			03/	12/2021
NAME OF P	ROVIDER OR SUPPLIER			l	STREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAND	NURSING AND REHAB	ILITATION CENTER		l	/30 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
F 695	use to keep them clear contamination. On 3/10/21 at 3:10 p. Resident #24's room. saw the problem. LP yankauer suction was the surface of the night mask was uncovered the nightstand and the stated that she would respiratory equipment (administrative staff mursing stated that the and procedures as the On 3/11/21 at approximate was made to ASM (ac #2, the director of nurstorage of nebulizer and in use and oxyger. On 3/12/21 at approximated via email that the policy for the storage equipment when not if oxygen administration. On 3/10/2021 at approximate approximate that the policy for the storage equipment when not if oxygen administration. On 3/10/2021 at approximate approximate that the policy for the storage equipment when not if oxygen administration. On 3/10/2021 at approximate approximate that the policy for the storage equipment when not if oxygen administration. On 3/10/2021 at approximate approximate that the policy for the storage equipment when not if oxygen administration. On 3/10/2021 at approximate approximate that the policy for the storage equipment when not if oxygen administration. On 3/10/2021 at approximate approximate that the policy for the storage equipment when not if oxygen administration.	in a plastic bag when not in al. and prevent m., LPN #3 observed LPN #3 stated that she N #3 stated that the I uncovered and touching Instand and the nebulizer and touching the surface of the suction machine. LPN #3 I remove the uncovered I Inately 10:30 a.m., ASM I thember) #2, the director of the facility used their policies their standard of practice. I mately 2:30 p.m., a request diministrative staff member) sing for the policy for not suction equipment when in administration. I mately 10:40 a.m., ASM #2 I he facility did not have a of nebulizer and suction in use and provided the in policy for review, i poximately 4:30 p.m., ASM	F	695			
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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495226	B, WING_			03/12/2021	
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL S.D. IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
F 695	Reference: 1. Nebulizer - a device medications for deliver Encyclopedia & Diction Allied Health - Seventi page 1182. 2. Yankauer suctionaspirate secretions from the secretions from the secretions from the secretion of the sec	e used to aerosolize bry to patients." Taken from mary of Medicine, Nursing & n Edition, Miller-Keane, a rigid suction tip used to om the oropharynx. This ned from the following action catheter. (n.d.) If the Health Professions and eved March 15 2021 from hary.thefreedictionary.com/Y neter e pulmonary disease t makes it difficult to breath hess of breath. This hed from the website: ov/medlineplus/copd.html.	F6	595			
F 698 SS≂D	down is an abnormal has a problem breath The head must be rai be able to breathe de information was obtai	ing difficulty while lying condition in which a person ing normally when lying flat. sed by sitting or standing to aply or comfortably. This ned from the website:	F6	598			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	B. WING			03/	12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LUNENBURG HIGHW EYSVILLE, VA 23947	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ζ.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 698	§483.25(I) Dialysis. The facility must ensurequire dialysis receive with professional stand comprehensive personal terms and clinical record revite facility staff failed dialysis services, constandards of practice, person-centered care residents, Resident # evidence ongoing concollaboration with the #7. The findings include: Resident #7 was adm 6/12/20. Resident #7 were not limited to: expending the facility of the kidney function in the mainter (1), mental disorder (a such as disturbance of emotional equilibrium) blood pressure) (3). Resident #7's most reset), a quarterly asses (assessment reference the resident as scoring the section of the section of the resident as scoring the section of the section of the resident as scoring the res	are that residents who re such services, consistent idards of practice, the in-centered care plan, and ind preferences. It is not met as evidenced wew, facility document review riew, it was determined that to ensure the provision of sistent with professional the comprehensive plan for one of 35 The facility staff failed to inmunication and dialysis center for Resident itted to the facility on the diagnoses included but t	F	988	Resident #7 receives dialysis Tuesday, Thursday, and Saturday. Th dialysis communication form was sent resident on his next dialysis day Satur 3/13/21 by the nurse. An audit of dialysis residents completed on 3/12/21 by the Director Nursing. The Dialysis Communication is sent with the resident in a packet th contains all needed information and D form when they leave for the appoint The facility will receive updated inform from the dialysis center via the communication form upon return to the facility. The Nurse will place the form i Medical Director book for review, if the any orders the MD will return to the nu The form is then given to Medical rece be placed in the chart. In-services for the nursing st be conducted on 3/29/21 by the Direc Nursing on the procedure for sending documenting receipt of communication from dialysis. The nurse will then docu under the dialysis progress note any information from the dialysis center. The Director of Nursing or designee will audit dialysis residents' of for communication forms and dialysis progress notes weekly x 4 weeks. The audit findings of dialysis communication forms and dialysis pro notes will be reviewed with QAPI mon 1 month.	was of form at NR nent. nation e in the ere are urse. ords to aff will tor of and n form ument charts	04/12/21

AND DI AN OF CORRECTION IN INCIDENTIFICATION NUMBER-			(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED		
		495226	B. WNG				03/	12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		730 LUNENE	DRESS, CITY, STATE, ZIP CO BURG HIGHW E, VA 23947	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		ON SHOULD BI HE APPROPRIA		(XS) COMPLETION DATE
F 698	locomotion and dress hygiene, bathing and Section H- bowel and as always incontinent A review of the nursin documented the follow-"3/4/21 at 11:21 AM, "Returned to facility a intact, no bleeding or of shunt site: + (positioniented per his norm-"3/6/21 at 9:58 AM, "Returned to facility for	oded the resident as assistance for bed mobility, ing, total dependence for eating. A review of MDS bladder coded the resident for bowel and bladder. If progress notes wing in part: documented in part, to 9:35 AM with dressing drainage noted. Condition live) bruit and thrill, alert and	F	398				
	noted". Resident #7's compres 3/27/20, documented renal disease: at risk hemodialysis. The Int documented, "Dialysi Saturday). Assess redialysis treatment and significant changes". A review of the dialys Resident #7 from 1/2. Tuesday, Thursday at treatments, evidence the dialysis communication. An interview was con AM with LPN (license	chensive care plan dated in part, Focus: "End state for complications due to erventions: dated 3/27/20, s (Tuesday, Thursday, sident upon return from dinotify physician of any discommunication forms for 1/21-3/11/21, a period of 30 and Saturday dialysis that 13 out of 30 (43%) of cation forms were missing.						
	asked the purpose of	the dialysis communication "It is to communicate the						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495226	B. WING			03/	12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES / NUST BE PRECEDED BY FULL (C) IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BI D TO THE APPROPRIA ICIENCY)	_	(X5) COMPLETION DATE
F 698	concerns". When ask communication from the form, LPN #1 stated, signs, weight, medication concerns". An interview was concerned and with ASM (adminitude director of nursing of the dialysis communicated, "It is for sharing resident between the lift there were any addition forms."	and any current issues or ed the purpose of the dialysis center on the bright transfer of the dialysis center on the bright transfer of the dialysis center on the bright transfer of the dialysis of the purpose of the	F	698			
		M, ASM (administrative administrator, ASM#2, the SM#3, the clinical #1, the regional vice	The state of the s				
	5/19/11 which docume shall ensure that all ap administrative informa	• -					
	No further information	was presented prior to exit.					
	References: (1) Barron Dictionary of edition, Rothenberg and (2) Barron Dictionary of edition, Rothenberg and (3) Barron Dictionary of (3) Barron Dictionary of (3)	nd Kaplan, page 498. of Medical Terms, 7th nd Kaplan, page 363.		* n		-1	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CCNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	B WING_		<u></u>	03/	12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAB	II:(TAT)ON CENTER		73	FREET ADDRESS, CITY, STATE, ZIP CODE 80 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	A LEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
F 698 F 700 SS≖E	CFR(s): 483.25(n)(1)- §483.25(n) Bed Rails. The facility must atternatives prior to in a bed or side rail is us correct installation, us rails, including but not elements. §483.25(n)(1) Assess entrapment from bed §483.25(n)(2) Review bed rails with the residence representative and obto installation. §483.25(n)(3) Ensure are appropriate for the second maintaining bed in This REQUIREMENT by: Based on observation document review, and was determined that the evidence documentations and contents assessments and contents.	nd Kaplan, page 282. (4) (4) Inpt to use appropriate stalling a side or bed rail. If sed, the facility must ensure se, and maintenance of bed limited to the following the resident for risk of rails prior to installation. The risks and benefits of dent or resident their informed consent prior that the bed's dimensions a resident's size and weight. the manufacturers' a specifications for installing ails. is not met as evidenced n, staff interview, facility I clinical record review, it the facility staff failed to ion of current side rail		398	F 700 Residents #21, #10, #2, and #have physical device use evaluations a consents signed by resident or resident representative completed by 3/26/21 by Director of Nursing. An audit of resident's beds framattress and side rail was completed of 3-24-21 by the Maintenance Director. A of physical device use evaluation assess in the clinical record will be completed by the Director of Nursing or designee, admission the nurse will complete the provided evaluation assessment in the clinical record, if the nurse determines the residued a side rail for mobility and/or transplaced on the assessment, the maintend director will be made aware to complete frame, mattress and side rail check, at screen referral will be completed, once determined the siderail is an appropriate approach the resident or resident representative will be notified to sign the consent and the side rail will be put into and the care plan will be updated. An in-service for clinical staff veconducted by 4/2/21 by the Director of on the physical device use evaluation assessment, notification to maintenance therapy and how to obtain consent from resident or resident representative if a signeded.	the mes, n audit syments on 4/2/21 Upon hysical nical dent will fers ance e the bed nerapy it is e place vill be Nursing e and the	

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
	24	495226	B. WING			14.010004
	ROVIDER OR SUPPLIER D NURSING AND REHAE	SILUTATION CENTER	7	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	1 03	/12/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	side rails up during the facility failed to evide assessment and a cut the side rails. Resident #21 was ad 4/4/2020 with diagnos not limited to: dement mental decline, especifudgement, often accident (1), and pulmonary fit formation of fibrous of normally as in scar for replace normal tissue. The most recent MDS assessment reference coded the resident as (brief interview for me she was severely impognitive decisions. Requiring extensive as bed. For moving in the was coded as only hat twice during the lookb assistance of one staff G0600 - Mobility Device on the following dates.	observed lying in bed with the course of the survey. The fince a current side rail frent consent for the use of mitted to the facility on the sest that included but were that included but were that (a progressive state of the sially memory function and tompanied by disorientation.) through the service of the tennective tissue, either froation, or abnormally to the especially in the lungs) (2). The fininimum data set) The sessessment, with an that date (ARD) of 1/11/2021, the scoring a "3" on the BIMS that status) score, indicating the error of the session of the the room or unit, the resident the performed this once or that set on the the room or unit, the resident the performed this once or the performance of the performance of the performed this the performance of the perf	F 700		evaluation uring the estraint/Side veeks. audit findings	04/12/21
	plan 4/15/20 revealed,	21's comprehensive care in part: "Use of bed rails aining current bed mobility				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UNMBER:			(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	B. WING		0:	3/12/2021
	ROVIDER OR SUPPLIER NURSING AND REHA	3)' BILITATION CENTER	730	REET ADDRESS, CITY, STATE, ZIP CODE D LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 700	transferAssess resisted from bed rails period necessaryevaluate continued effectiven appropriatenessus resident to increase bed at highest practibedrails to assist resisted in bed." Further review of Refailed to reveal evide assessment or cons. On 3/11/21 at 2:00 p staff member) #1, the director of nursing, consultant, and ASM vice-president, were ASM #2 stated an aresident safety on or quarterly with each of stated if side rail use place, and are documplan. ASM #2 stated process for checking are put up." She stated	uscle weakness, safety in sident for risk of entrapment dically and as a use of device periodically for ess and se of bedrails to assist ability to enter and exit the ical mobility leveluse of sident to turn and reposition esident #21's clinical record ence of a current side rail ent for the use of side rails. a.m., ASM (administrative e a aministrator, ASM #2, the ASM #3, the clinical first, the regional informed of these concerns. In the care plan conference. She is indicated, they are put into mented on the resident's care It, "I don't know there is a gother they ted the facility's side rail len off" of the computer	F 700			
	used to enhance res and from the bed, or keep residents from Use of side rails as a they are necessary	ty policy, "Side Rail d, in part: "Side rails may be sident mobility and transfer to r as a restraining device to voluntarily getting out of bed, a restraint is prohibited unless to treat a resident's medical icy did not address the				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		٠ ن٠	495226	B. WING			03/	12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAE	BILITATION	CENTER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW (EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
F 700	Continued From pag facility's assessment No further informatio REFERENCES (1) Barron's Dictional Non-Medical Reader Chapman, page 124. (2) Barron's Dictional Non-Medical Reader Chapman, page 227.	process. n was provery of Medito ry of Medito ry of Medito cth editio	cal Terms for the n, Rothenberg and cal Terms for the	F	700			
	2. Resident #10 was side rails up during the facility failed to evide assessment and a cuthe side rails. Resident #10 was ad 5/4/2016 with diagnounce limited to: Alzheir loss of mental ability	ne course of the	of the survey. The ent side rail ent for the use of the facility on cluded but were use (a progressive					
	accompanied by pers emotional instability.) (a slowly progressive characterized by rest stooped posture, rolli drooling and muscle emotional instability)	onality change (i) and Paneurologic ing tremoring motions weakness,	anges and arkinson's disease cal disorder , shuffling gait, s of the fingers,					
,	The most recent MDS assessment, a quarte assessment reference the resident as scorir interview for mental s resident was severely cognitive decisions. F	orly assess e date of 1 g a "3" on talus) sco o impaired	ment, with an 2/21/2020, coded the BIMS (brief re, indicating the to make daily	=				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA . IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495226	B. WING _	B. WING		03/12/2021	
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 700	room or unit, the resident totally dependent upon Section G0600 - Mobi was coded as using a consider the following date was observed lying in 3/9/21 at 3:26 p.m., 3 at 9:48 a.m. A review of Resident plan, dated 10/24/18 revealed, in part: "Uson maintaining currenability. Muscle weakind DiseaseCheck bed functioningevaluate for continued effective appropriatenessuser resident to increase a bed at highest practic. Further review of Resident practic. Further review of Resident to increase a bed at highest practic. Further review of Resident to increase a consultant to increase a bed at highest practic. Further review of Resident to increase a consultant of a consultant of a consultant, and ASM vice-president, were a ASM #2 stated an as resident safety on ori quarterly with each consultant, and are documentally in the consultant of the c	ssistance of one staff in the bed. For moving in the ident was coded as being in one staff member. In ility Devices, the resident is wheelchair. Is and times, Resident #10 is bed with both side rails up: /10/21 at 8:55 a.m., 3/11/21 #10's comprehensive care and revised on 11/11/20, is of bed rails for increasing it bed mobility or transfer ess, Parkinson's rails periodically for proper use of device periodically eness and is of bedrails to assist ability to enter and exit the isal mobility level." Isident #10's clinical record ince of a current side rail int for the use of side rails. In., ASM (administrative administrator, ASM #2, the SM #3, the clinical	F7				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495226	B. WING _		0	3/12/2021	
	ROVIDER OR SUPPLIER NURSING AND REHAL	BILITATION CENTER	-11	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				SHOULD BE	(X5) COMPLETION DATE	
F 700	Continued From pag	e 73	F 70	00			
	are put up." She stat assessment had "fall software for some of	the side rails before they ed the facility's side rail len off" of the computer the residents.					
		ry of Medical Terms for the , 5th edition, Rothenberg and					
		ry of Medical Terms for the , 5th edition, Rothenberg and					
	side rails up during the facility staff failed to	observed lying in bed with ne course of the survey. The evidence a current side rail urrent consent for the use of					
ll	and was recently rea diagnoses that included dementia (a progress	nitted to the facility 5/17/2015 dmitted on 2/23/2021 with fed but were not limited to: sive state of mental decline, unction and judgement, often					
	accompanied by disc pressure and schizor mental disorders cha distortions of reality,	orientation.)(1), high blood ohrenia (Any of a group of					
	assessment, a signification with an assessment	S (minimum data set) icent change assessment, reference date of 3/2/2021, s having no difficulty with					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495226	B. WING	***		03/12/2021	
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 730 LUNENBURG HIGHW KEYSVILLE, VA 23947)DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 700	short or long-term me #2 was coded as req of one staff member of Resident #2 was cod assistance of one sta their room or unit. In Devices, the resident wheelchair. On the following date was observed lying ir 3/9/21 at 11:16 a.m., A review of Resident plan dated 10/24/18 or rails for increasing or mobility or transfer at transfers Assess ref from bed rails periodi necessary Check be proper functioninge periodically for contin appropriateness use resident to increase a bed independently." Further review of Res failed to reveal evide assessment or conse On 3/11/21 at 2:00 p. staff member) #1, the director of nursing, A consultant, and ASM vice-president, were ASM #2 stated an as resident safety on or quarterly with each c	emory difficulties. Resident uiring extensive assistance for moving in the bed. ed as requiring limited off member for moving in Section G0600 - Mobility was coded as using a as and times, Resident #2 an i.ed with both side rails up. 3/10/21 at 9.03 a.m. #2's comprehensive care revealed, in part: "Use of bed maintaining current bed boility. Safety in sident for risk of entrapment cally and as and rails periodically for evaluate use of device and effectiveness and a of bedrails to assist ability to enter and exit the sident #2's clinical recordince of a current side rail and for the use of side rails. m., ASM (administrative administrator, ASM #2, the ASM #3, the clinical	F	700			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495226	B. WING		03/12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	03/12/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
	plan. ASM #2 stated, process for checking to are put up." She state assessment had "falle software for some of the software for some software for some software for some software for software for some software for some software for sof	ented on the resident's care "I don't know there is a the side rails before they d the facility's side rail off" of the computer the residents. was provided prior to exit. y of Medical Terms for the 5th edition, Rothenberg and of Medical Terms for the 5th edition, Rothenberg and bserved lying in bed with a course of the survey. The ce a current side rail rent consent for the use of witted to the facility on ses that included but were the sisease (a slowly al disorder characterized filing gait, stooped posture, ingers, drooling and muscle with emotional instability) willure (abnormal condition ofter by the kidneys) (2) and with disorder characterized and depression) (3).	F 70		

	MENT OF DEFICIENCIES LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING		0	(73) DATE SURVEY COMPLETED		
		495226	B. WING	B. WING		03/12/2021
	ROVIDER OR SUPPLIER D NURSING AND REHAL	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 700	assessment, a quart assessment reference the resident as scorii interview for mental resident was capable decisions. Resident ilimited assistance of moving in the bed. Requiring supervision moving in their room Mobility Devices, the a wheelchair. On the following date was observed lying is 3/9/21 at 11:27 a.m., A review of Resident plan, dated 12/29/17 revealed, in part: "Us or maintaining currer ability. Muscle weak Other: maintain inde mobility Assess resfrom bed rails period necessary Check be proper functioning eperiodically for continuity appropriatenessproresident and/or resident and/or resident and/or resident and/or resident and/or reveal evide assessment or consider the consideration of the unit of the consideration of the cons	erly assessment, with an ce date of 1/20/2021, coded on a "14" on the BIMS (brief status) score, indicating the cof making daily cognitive #32 was coded as requiring one staff member for the death #32 was coded as a with set up assistance for or unit. In Section G0600 - cresident was coded as using es and times, Resident #32 on bed with both side rails up. 3/11/21 at 8:52 a.m. #32's comprehensive care and updated 12/14/20, se of bed rails for increasing on the demobility or transfer mess. Safety in transfers. Expendence with bed ident for risk of entrapment identifically and as ed rails periodically for evaluate use of device mused effectiveness and ovide and review with lent's representative the risks se of side rails." sixtent #32's clinical recordence of a current side rail ent for the use of side rails. .m., ASM (administrative endministrator, ASM #2, the	F	700		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
 		495226	8. WING			3/12/2021	
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(X5) COMPLETION DATE		
F 700	consultant, and ASM vice-president, were in ASM #2 stated an ass resident safety on original quarterly with each castated if side rail use in place, and are documplan. ASM #2 stated, process for checking are put up." She state assessment had "falle software for some of the No further information REFERENCES	#4, the regional ntormed of these concerns, sessment was performed for ginal admission, and then as plan conference. She is indicated, they are put into ented on the resident's care it don't know there is a the side rails before they d the facility's side rail an off' of the computer	F	700			
F 730 SS≉D	Non-Medical Reader, Chapman, page 437. (2) Barron's Dictionary Non-Medical Reader, Chapman, page 138. (3) Barron's Dictionary Non-Medical Reader, Chapman, page 72. Nurse Aide Peform Rec CFR(s): 483.35(d)(7) §483.35(d)(7) Regular The facility must compof every nurse aide at months, and must proeducation based on the	of Medical Terms for the 5th edition, Rothenberg and of Medical Terms for the 5th edition, Rothenberg and of Medical Terms for the 5th edition, Rothenberg and eview-12 hr/yr In-Service in-service education. Polete a performance review least once every 12 vide regular in-service e outcome of these alining must comply with the	F 7	730			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495226	B. WING		03/	12/2021	
	ROVIDER OR SUPPLIER NURSING AND REHAB	SILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFiX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
F 730	by: Based on staff intervand facility document the facility staff failed performance review for nursing assistants), Cand CNA #4. The findings include: An email requesting to reviews was sent to Amember) #1, the admidirector of nursing on 3/9/2021, 6.09 p.m. Adocumented, "Employevaluations of (due to for nursing) turnover, of beginning them." CNA #1 was hired on performance evaluations of the control of th	riew, employee record review review, it was determined to perform an annual for four of 12 CNAs (certified CNA #1, CNA #2, CNA #3, the CNA annual performance ASM (administrative staff ninistrator, and ASM #2, the 13/9/2021 at 4:10 p.m. On ASM #2 replied by email and	F 73	• CNA #1, #2, #3 and #4 to a Employee performance review on 3 the Director of Nursing. • Audit of clinical staff employee to be completed by 4/2/21, the audit conducted by the Director of Nursing Staff Development Coordinator. Per evaluations are to be conducted and ensure Certified Nursing Assistants twelve (12) hours of in-servicing per performance evaluation will include completion of a yearly competency • An in-service was done with Director of Nursing on 3/24/21 by the Consultant on the policy and proced annual performance evaluations to a review of CNA requirements of 12 h services per year and annual compareview per the requirements for the Commonwealth of Virginia. An in-section of competency checklist comply with requirements for the Commonwealth of Virginia, this will completed by 4/2/21 by the Director The Administrator will audit staff performance evaluations comp DON to include 4 CNA files for cominclude in-servicing and competency weekly x 4 weeks. If any areas of condentified the Administrator will mak aware immediately for correction. • The audit findings will be returned.	yment file will be g and the formance hually to receive year. The the eview. h the e Facility ure for nclude ours of instency rvice will be ing and annually to be of Nursing. t 5 clinical leted by the pletion to y 1-time oncern are a the DON eviewed in		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495226	B. WING		03/12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
	gotten a list a week or resources as to who is reviews and was going gotten to them. When the DON, ASM #2 stated or now, ASM #2 stated or DON position and the A request was made of for a policy and proceperformance reviews, at 10.40 a.m. docume policy on annual performance of the policy of the pol	r two ago from human needed annual performance of to start them but hasn't asked when she started as atted February 1, 2021. When not been completed prior to due to the turnover of the pandemic. On 3/11/2021 at 2:21 p.m. dure on annual An email dated 3/12/2021 anted they did not have a premance reviews. Avare of the above findings p.m. ASM #1, the ade aware of the above at 9:48 a.m. I was provided prior to exit. d Biologicals 1)(2) of Drugs and Biologicals used in the facility must be a with currently accepted and cautionary	F 761	F 761	from ter, ney and ops
	§483.45(h) Storage of §483.45(h)(1) In acco Federal laws, the facil biologicals in locked of	Drugs and Biologicals rdance with State and ity must store all drugs and ompartments under proper and permit only authorized		An audit was conducted of the medication carts and medication rooms 3/11/12 by the Director of Nursing and Facility Consultant. Any areas of concidentified were corrected immediately. The nurses will be in-serviced 3/29/21 by the Director of Nursing on Pharmacy policy and procedure for expendication and medical surplies. The	on the ern on

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	B. WING			03/12/2021	
WAYLAND	ROVIDER OR SUPPLIER NURSING AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CGDE 730 LUNENBURG HIGHW KEYSVII.LE, VA 23947				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF	PROVIDER'S PLAN OF CORRECTIVE PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIATE OF T			(X5) COMPLETION DATE
F 761	personnel to have accessed by the Comprehensive December of Control Act of 1976 at abuse, except when the package drug distributed quantity stored is minimal be readily detected. This REQUIREMENT by: Based on observation determined that the factorial actions and available for use in rooms observed, (the room) and in one of o observed, (300 Hall material of the Eadministrative staff materials. Observation of the BM was conducted in the Eadministrative staff materials. Observation date on the far right room, revealed two 10 water [1] located on the The two 10 mL vials of with an expiration of a wall. Observation of a wall.	cess to the keys. The stillty must provide separately affixed compartments for drugs listed in Schedule II of trug Abuse Prevention and and other drugs subject to the facility uses single unit tion systems in which the simal and a missing dose can it is not met as evidenced in and staff interview it was acility staff failed to ensure and medical supplies were in one of one medication 18/A medication carts are dication carts. Eximately 3:10 p.m., an a medication storage room presence of ASM [sember] # 2, director of	F	761	shift nurse will review the facility medicates and medication rooms for any exmedication and medical supplies night medication or medical supply found to expired will be removed from use, the will be notified, and the item will be dis of per the Pharmacy policy and procedmanual. The 11-7 shift nurse will come the checklist review from the medication charts and medication rooms and turn DON daily. The DON or designee will the medication carts and medication retime weekly x 4 weeks. The audit findings will be review the monthly QAPI committee meeting month.	spired tly, any be DON sposed dure plete on into the audit coms 1-	04/12/21
	entering the room rev	ealed one full, unopened 25 mg (milligrams), 100					

	OF DEFICIENCIES CORRECTION				(X3) DATE SURVEY COMPLETED	
		495226	B. WING		03	/12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y JUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 761	count tablets with an orange count tablets with an orange count tablets with an experience of the country of th	expired date of February e. f on the back wall of the com of revealed one er] Kit With Gloves and ed date of "2021-01-31 evailable for use. Froximately 3:30 p.m., an 2 was conducted regarding d in the medication room. The above items should have eximately 8:11 A.m., an fility's 300 Hall medication ith LPN (licensed practical on of the medication cart corops" revealed the eye drop bottle of Xalatan servation of the bottle date of 1/24/20. Further the documented, "Expires 6 An interview was E 1 at this time. LPN #1	F 7	761		
2	interview was conduct nursing. After examin ASM # 2 stated that th half full. When asked staff follows to make s are not available for u third shift nurses are t	roximately 8:25 a.m., an ted with ASM # 2, director of ling the bottle of Xalatan, he bottle was approximately to describe the procedure sure expired medications se ASM # 2 stated, "The o go through the med I the medication rooms			2	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	77.0	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495226	B, WING _	B-644 C-644 A-644	0	3/12/2021	
	ROVIDER OR SUPPLIER NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	CODE		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 761	Continued From pag	je 82	F 7	' 6·1			
1270,200	They use a checklist a nurse sees an exp they should remove		ALL STREET, AND ST				
	(administrative staff administrator, and S were made aware of	AM # 2; director of nursing the findings.	er ger festjo-stern de priksser pliksbeser pliksbeser pliksbeser pliksbeser pliksbeser				
	No further information	in was provided prior to exit.					
	obtained from the we	This information was absite: gov/ency/patientinstructions/0	describing and subjective committees of the s				
	and to relieve mild to headaches, menstru toothaches, and must aspirin is also used to people who have ha who have angina, repeople who are experemently experienced ischemic strokes, mithemorrhagic strokes production of certain cause fever, pain, so	It works by stopping the natural substances that welling, and blood clots. This					
	https://medlineplus.g tml. [3] Also known as La	ained from the website: gov/druginfo/meds/a682878.h atanoprost. Used to treat rost comes as eye drops.					
	This information was	s obtained from the website: gov/druginfo/meds/a697003.h					

F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION		TE SURVEY MPLETED
	495226	B. WING			3/12/2021
OVIDER OR SUPPLIER	IL:TATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	OTION SHOULD BE OTHE APPROPRIATE	(X5) COMPLETION DATE
tml Food Procurement, St CFR(s): 483.60(i)(1)(2) §483.60(i) Food safet The facility must - §483.60(i)(1) - Procur approved or considere state or local authoriti (i) This may include fo from local producers, and local laws or regu (ii) This provision doe facilities from using pr gardens, subject to co safe growing and food (iii) This provision doe from consuming foods §483.60(i)(2) - Store, serve food in accorda standards for food ser This REQUIREMENT by: Based on observation determined facility sta sanitary manner.	ore/Prepare/Serve-Sanitary y requirements e food from sources ed satisfactory by federal, es. od items obtained directly subject to applicable State elations. Is not prohibit or prevent roduce grown in facility tompliance with applicable elations are not preclude residents is not preclude residents is not procured by the facility. prepare, distribute and in the with professional evice safety. is not met as evidenced in and staff interview it was		F-812 The Ceiling fan was remduring the survey and was covered light fixture by the Director. An audit was completed Administrator of all other There were no other ceiling fans in the kitchen area. An in-service was complestaff on 3/12/21 by Food regarding serving food in The Administrator will auxa meal service to ensure sanitary manner weekly monthly x 1 month utilizing tool. Results of the kitchen auxeviewed by the QA/PI Comonthly meeting to ensure	as replaced by a me Maintenance on 3-12-21 by the kitchen ceiling fans ing fans or portable eted with the kitchen Service Manager a sanitary manner, and the kitchen during food is served in a x 4 weeks then and a kitchen audit tools will be committee at its are continued	
facility's kitchen was of resident's lunch transcription of the cetthe steam table when	conducted during the plating ys. iling above the right end of standing behind the steam			§	
	OVIDER OR SUPPLIER NURSING AND REHAB SUMMARY STY (EACH DEFICIENCY REGULATORY OR L Continued From page tml Food Procurement, St CFR(s): 483.60(i)(1)(2) §483.60(i) Food safet The facility must - §483.60(i)(1) - Procur approved or considere state or local authoriti (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using pr gardens, subject to co safe growing and food (iii) This provision doe from consuming foods §483.60(i)(2) - Store, serve food in accorda standards for food ser This REQUIREMENT by: Based on observation determined facility sta sanitary manner. The findings include: On 03/09/20 at 12:00 facility's kitchen was co of resident's lunch trai Observation of the ce the steam table when	OVIDER OR SUPPLIER NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 83 tml Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordar: 2e with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined facility staff failed to serve food in a sanitary manner.	OVIDER OR SUPPLIER NURSING AND REHABIL:TATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 83 tml Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) \$483.60(i) Food safety requirements The facility must - \$483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. \$483.60(i)(2) - Store, prepare, distribute and serve food in accordar, 2e with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined facility staff failed to serve food in a sanitary manner. The findings include: On 03/09/20 at 12:00 p.m., an observation of the facility's kitchen was conducted during the plating of resident's lunch trays. Observation of the ceiling above the right end of the steam table when standing behind the steam	OVIDER OR SUPPLIER A 95226 STREET ADDRESS, CITY, STATE, 21P 730 LUMENBURG HIGHW KEYSVILLE, VA 23947 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION) Continued From page 83 tml Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) \$483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not proclude residents from consuming foods not procured by the facility, gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not procured by the facility, \$483.60(i)(2) - Store, prepare, distribute and serve food in accordar.2 with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined facility staff failed to serve food in a sanitary manner. The findings include: On 03/09/20 at 12:00 p.m., an observation of the facility's kitchen was conducted during the plating of resident's lunch trays. Observation of the ceiling above the right end of the steam table when standing behind the steam	OWDER OR SUPPLIER 495226 B. WING STREET ADDRESS, CITY, STATE, 2IP CODE 730 LUNENBURG HIGHW KEYSYLLE, VA 23947 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) Continued From page 83 Froil Food Procurement, Store/Prepare/Serve-Sanitary CPR(s), 483.80(1)(10)2 \$483.80(1) Food safety requirements The facility must - \$483.60(1)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This provision does not prohibit or prevent facilities from using produce grown in facilities growing and food-handing practices. (ii) This provision does not protectude residents from consuming foods not procured by the facility gardens, subject to compliance with applicable safe growing and food-handing practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. \$483.60(1)(2) - Store, prepare, distribute and serve food in accordar: a with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined facility staff failed to serve food in a sanitary manner. The findings include: On 03/09/20 at 12:00 p.m., an observation of the facility skitchen was conducted during the plating of resident's lunch trays.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 0 000	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495226	B. WING		03/12/2021
	ROVIDER OR SUPPLIER D NURSING AND REHAB	10	7	TREET ADCRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW EYSVILLE, VA 23947	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y JAUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
	on the ceiling, operatiplating of resident's for After all the resident's approximately 12:30 was asked to turn off right end of the steam fan blades and motor revealed that they had in an interview with Offindings that the fan blades and the were coated in dust. The turned it off before I sturn the fan off when asked why it gets turn the food doesn't cool On 03/10/2021 at application of the firm administrative staff or administrative	food. It food was plated at o.m., the OSM #1, the cook the ceiling fan above the otable. Observation of the housing with OSM # 1, do a coating of dust on them. It is food was and motor housing OSM # 1 stated, "I should've traited to serve. Usually I serving the trays." When need off OSM # 1 stated, "So down and not blow any dust. It is food was provided prior to exit. It Regular inspection of all es, and bed rails, if any, as tenance program to identify rapment. When bed rails sed and purchased ed frame, the facility must ails, mattress, and bed	F 909	F-909 Bed side rail safety assessments were completed for resident #21, #10, #2 and 3/26/2521 by DON Safety assessments were completed on other residents with bed rails on DON of designee by 4/8/21. The Administrator completed an in-servithe maintenance director on 3/18/21 region completing bed rail assessments. The Maintenance Director will complete assessments for all residents with bed riversidents and the complete continued compliance monthly x 1 month. Date of Compliance April 12,2021.	a all f ice with garding bed rail ails ety tools

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		Si .	(X3) DATE SURVEY COMPLETED	
		495226	B. WING		MA	03/-	12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAI	BIETTATION CENTER		STREET ADDRESS, CITY, STA 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	ATE, ZIP CODE		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 909	Continued From pag	e 85	F	909			
	evidence documenta safety assessments survey sample, Resi	the facility staff failed to tion of current bed/side rail for four of 35 residents in the dents #21, #10, #2, and #32.				77 27 27 27 27 27 27 27 27 27 27 27 27 2	
	The findings include:						
	side rails up during ti	observed lying in bed with ne course of the survey. The ince a current bed/side rail or the resident.				:	
	4/4/2020 with diagnorm not limited to: demense mental decline, espejudgement, often acc (1), and pulmonary fiformation of fibrous comments.	inditted to the facility on uses that included but were state of cally memory function and companied by disorientation.) brosis (an increase in the connective tissue, either					
		ormation, or abnormally to e especially in the lungs) (2).					
	assessment, quarteri assessment reference	S (minimum data set) ly assessment, with an le date of 1/11/2021, coded					
:	interview for mental s was severely impaire decisions. Resident s extensive assistance moving in the room of	ng a "3" on the BIMS (brief status) score, indicating she and to make daily cognitive \$21 was coded as requiring for moving in the bed, or unit, the resident was					
	twice during the look assistance of one sta	off member. In Section rices, the resident was coded	• *	250		7#2 01-2	
		es and times, Resident #21 n bed with both side rails up:		8 8 8 4 1			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	TIPLE CONSTRUCTION NG	(X3)	(X3) DATE SURVEY COMPLETED	
		495226	B. WING			03/12/2021	
	ROVIDER OR SUPPLIER NURSING AND REHAB	BILYTATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 909	3/11/21 at 9:46 a.m. A review of Resident plan 4/15/20 revealer for increasing or main or transfer ability. MutransferAssess res from bed rails periodinecessaryevaluate continued effectivene appropriatenessuse resident to increase a bed at highest practic bedrails to assist resimbed assist resimber in bed." Further review of Refailed to reveal evide safety assessment. On 3/11/21 at 2:00 p. staff member) #1, the director of nursing, A consultant, and ASM vice-president, were ASM #2 stated, "I do for checking the side On 3/11/21 at 12:39 member) #9, the main interviewed. When assafety inspections, he with an outside compand do these inspectineither he nor ASM # aware of the name of	#21's comprehensive care d, in part: "Use of bed rails intaining current bed mobility iscle weakness, safety in ident for risk of entrapment ically and as use of device periodically for ess and e of bedrails to assist ability to enter and exit the cal mobility level use of ident to turn and reposition is it at #21's clinical record ince of a current bed/side rail informed of these concerns. In the regional informed of these concerns. In the know there is a process rails before they are put up." D.m., OSM (other staff intenance director, was sked about bed and side rail as stated the facility contracts approached in the facility contracts any to come into the facility ion. OSM #9 stated that £1, the administrator was for that contract company, and y to contact the company	F	909			

PRINTED: 03/17/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(.:1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED	
= =: =		495226	B WING			03/12/2021	
	ROVIDER OR SUPPLIER NURSING AND REHAB	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 909	used to enhance resident from the bed, or a keep residents from the Use of side rails as a they are necessary to symptoms." The policifacility's process for binspections. No further information REFERENCES (1) Barron's Dictional Non-Medical Reader, Chapman, page 124. (2) Barron's Dictional Non-Medical Reader, Non-Medical Reader, Non-Medical Reader, Reader	r policy, "Side Rail in part: "Side rails may be dent mobility and transfer to as a restraining device to coluntarily getting out of bed, restraint is prohibited unless treat a resident's medical y did not address the	F 9	909			
	side rails up during the facility failed to evider assessment for the research for the rese	mitted to the facility on ses that included but were her's disease (a progressive and function, often onality changes and (1) and Parkinson's disease					

+ أن تنتخب

F 909 Continued From page 88 enotional instability) (2). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/21/2020, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. Resident #10 was coded as requiring extensive assistance of one staff member for moving in the bed. For moving in the room or unit, the resident was coded as being totally dependent upor; one staff member. In Section G0600 - Mobility Devices, the resident was coded as using a '\times ended with both side rails up: 3/9/21 at 3:26 p.m., 3/10/21 at 8:55 a.m., 3/11/21 at 9:48 a.m. A review of Resident #10's comprehensive care plan, dated 10/24/18 and revised on 11/11/20, revealed, in part: "Use of bed rails for increasing or maintaining current bed mobility or transfer ability. Muscle weakness, Parkinson's DiseaseCheck bed rails periodically for proper functioningevaluate use of device periodically for continued effectiveness and	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			
WAYLAND NURSING AND REHABILITATION CENTER X4] ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPRICENCY MUST BE PRECEDED BY PULL (EACH DEPRICENCY MUST BE PRECEDED BY PULL (EACH DEPRICENCY MUST BE PRECEDED BY PULL (REGULATIONY OR LSC DEMIFYING INFORMATION) PREFIX TAG			· 495226	8. WING		0	3/12/2021
F 909 Continued From page 88 enotional instability) (2). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/21/2020, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. Resident #10 was coded as requiring extensive assistance of one staff member for moving in the bed. For moving in the room or unit, the resident was coded as being totally dependent upor; one staff member. In Section G0600 - Mobility Devices, the resident was coded as using a '\times ended with both side rails up: 3/9/21 at 3:26 p.m., 3/10/21 at 8:55 a.m., 3/11/21 at 9:48 a.m. A review of Resident #10's comprehensive care plan, dated 10/24/18 and revised on 11/11/20, revealed, in part: "Use of bed rails for increasing or maintaining current bed mobility or transfer ability. Muscle weakness, Parkinson's DiseaseCheck bed rails periodically for proper functioningevaluate use of device periodically for continued effectiveness and			BILITATION CENTER	730 L	UNENBURG HIGHW		
emotional instability) (2). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/21/2020, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. Resident #10 was coded as requiring extensive assistance of one staff member for moving in the bed. For moving in the room or unit, the resident was coded as being totally dependent upor; one staff member. In Section G0600 - Mobility Devices, the resident was coded as using a heelchair. On the following dates and times, Resident #10 was observed lying in bed with both side rails up: 3/9/21 at 3:26 p.m., 3/10/21 at 8:55 a.m., 3/11/21 at 9:48 a.m. A review of Resident #10's comprehensive care plan, dated 10/24/18 and revised on 11/1/120, revealed, in part. "Use of bed rails for increasing or maintaining current bed mobility or transfer ability. Muscle weakness, Parkinson's DiseaseCheck bed rails periodically for proper functioningevaluate use of device periodically for continued effectiveness and</td <td>PREFIX</td> <td>(ÉACH DEFICIEN</td> <td>ICY MUST BE PRECEDED BY FULL</td> <td>PREFIX</td> <td>(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE</td> <td>I SHOULD BE</td> <td>(X5) COMPLETION DATE</td>	PREFIX	(ÉACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	I SHOULD BE	(X5) COMPLETION DATE
appropriatenessuse of bedrails to assist resident to increase ability to enter and exit the bed at highest practical mobility level." Further review of Resident #10's clinical record failed to reveal evidence of a current bed/side rail safety assessment. On 3/11/21 at 2:00 p.m., ASM (administrative	F 909	enrotional instability The most recent MD assessment, a quar assessment referenthe resident as scorinterview for mental resident was severe cognitive decisions. requiring extensive member for moving room or unit, the restotally dependent up Section G0600 - Mo was coded as using On the following dat was observed lying 3/9/21 at 3:26 p.m., at 9:48 a.m. A review of Residen plan, dated 10/24/13 revealed, in part: "U or maintaining curre ability. Muscle weak DiseaseCheck be functioningevalua for continued effecti appropriatenessus resident to increase bed at highest pract Further review of Re failed to reveal evid safety assessment.	DS (minimum data set) terly assessment, with an oce date of 12/21/2020, coded ing a "3" on the BIMS (brief status) score, indicating the ely impaired to make daily. Resident #10 was coded as assistance of one staff in the bed. For moving in the sident was coded as being bort one staff member. In a Cheelchair. Ites and times, Resident #10 in bed with both side rails up: 3/10/21 at 8:55 a.m., 3/11/21 at #10's comprehensive care and revised on 11/11/20, lise of bed rails for increasing and bed mobility or transfer the assignments, Parkinson's drails periodically for proper te use of device periodically veness and se of bedrails to assist ability to enter and exit the tical mobility level." esident #10's clinical record ence of a current bed/side rail	F 909			

	DF DEFICIENCIES . CORRECTION	(31) PROVIDER/SUPPLIER/CÜA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	B. WING_			03/	12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
F 909	director of nursing, A consultant, and ASM vice-president, were in	SM #3, the clinical	FS	09			
	on 3/11/21 at 12:39 p member) #9, the mair interviewed. When as safety inspections, he with an outside compa and do these inspection either he nor ASM #1 aware of the name of	rails before they are put up." .m., OSM (other staff intenance director, was ked about bed and side rail stated the facility contracts any to come into the facility on. OSM #9 stated that the administrator was that contract company, and it to contact the company	The state of the s			(*)	
	REFERENCES (1) Barron's Dictionary Non-Medical Reader, Chapman, page 26. (2) Barron's Dictionary	was provided prior to exit. y of Medical Terms for the 5th edition, Rothenberg and y of Medical Terms for the 5th edition, Rothenberg and					
	side rails up during the facility failed to product assessment for the re Resident #2 was adm and was recently read diagnoses that include dementia (a progressi	oserved lying in bed with en course of the survey. The control of the survey of the survey. The control of the survey of the survey. The survey of the survey of the survey of the survey. The survey of the survey. The survey of	<u>*</u> 9 €			*	

	OF DEFICIENCIES CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	130 100	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495226	B. WING		03/	12/2021
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF: TAG			(X5) COMPLETION DATE
F 909	pressure and schizop mental disorders chardistortions of reality, vianguage, perception (2). The most recent MDS assessment, a signific with an assessment recoded the resident as short or long-term me resident was coded a assistance of one staff bed. Resident #2 requipments of the section G0600 - Moreover Market Was coded as using a coded as u	rientation.)(1), high blood hrenia (Any of a group of acterized by gross withdrawal of thought, and emotional response) 6 (minimum data set) cant change assessment, eterence date of 3/2/2021, having no difficulty with thory difficulties. The sequiring extensive of member for moving in the uired limited assistance of moving in their room or unit, oblity Devices, the resident wheelchair. 8 and times, Resident #2 bed with both side rails up: 3/10/21 at 9:03 a.m. #2's comprehensive care evealed, in part: "Use of bed maintaining current bed illity. Safety in ident for risk of entrapment cally and as d rails periodically for valuate use of device used effectiveness and	F	909		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	B. WING		03/12/2021	
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 909	staff member) #1, the director of nursing, A consultant, and ASM : vice-president, were is	m., ASM (administrative administrator, ASM #2, the Si/I #3, the clinical #4, the regional nformed of these concerns.	₽ 909			
	for checking the side	't know there is a process rails before they are put up."				
	safety inspections, he with an outside compa and do these inspection either he nor ASM # aware of the name of	ntenance director, was ked about bed and side rail stated the facility contracts any to come into the facility on. OSM #9 stated that 1, the administrator was that contract company, and to contact the company				
	No further information	was provided prior to exit.				
	1	ry of Medical Terms for the 5th edition, Rothenberg and				
	V-7	y of Medical Terms for the 5th edition, Rothenberg and				
	side rails up during th	observed lying in bed with e course of the survey. The co a current bed/side rail sident.				
	Resident #32 was add	nitted to the facility on oses that included but were				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495226	B. WNG			03/	12/2021	
	NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER			730	REET ADDRESS, CITY, STATE, ZIP CODE 0 LUNENBURG HIGHW EYSVILLE, VA 23947			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 909	not limited to: Parkins progressive neurologic by resting tremor, shur rolling motions of the weakness, sometimes (1), congestive heart is characterized by circuretention of salt and with bipolar disorder (a methy episodes of mania). The most recent MDS assessment, a quarte assessment reference the resident as scoring interview for mental stresident was capable decisions. The resident limited assistance of comoving in their room of Mobility Devices, the read wheelchair. On the following dates was observed lying in 3/9/21 at 11:27 a.m., 3 A review of Resident is plan, dated 12/29/17 revealed, in part: "Use or maintaining current ability. Muscle weakned Other: maintain indeptions."	con's disease (a slowly cal disorder characterized offling gait, stooped posture, fingers, drooling and muscle is with emotional instability) failure (abnormal condition alatory congestion and vater by the kidneys) (2) and cater by the kidneys) (2) and cater by the kidneys) (3). If (minimum data set) rily assessment, with an expected and depression) (3). If (minimum data set) rily assessment, with an expected and depression) (5). If (minimum data set) rily assessment, with an expected and depression) (5). If (minimum data set) rily assessment, with an expected ga "14" on the BIMS (brief tatus) score, indicating the of making daily cognitive into the was coded as requiring one staff member for exident #32 was coded as with set up assistance for or unit. In Section G0600 - resident was coded as using and times, Resident #32 and times, Resident #33 and times, Resident #34 and times #34 and times #35 and times	F	909				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
	= v	495226	B. WING _		03/12/2021	
	ROVIDER OR SUPPLIER NURSING AND REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT 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 APPROPI DEFICIENCY)	BE COMPLETE	ON
F 909	Continued From page 93 periodically for continued effectiveness and appropriatenessprovide and review with		F 96	09		:
	and benefits of the use	nt's representative the risks e of side rails." iuent #32's clinical record				
	failed to reveal eviden safety assessment.	ce of a current bed/side rail				
	staff member) #1, the director of nursing, AS consultant, and ASM #	4, the regional				
	ASM #2 stated, "I don'	nformed of these concerns. It know there is a process alls before they are put up."				
	safety inspections, he with an outside compa and do these inspection					
10 mm 1 m	aware of the name of	that contract company, and to contact the company				
	No further information	was provided prior to exit.				
		of Medical Terms for the bth edition, Rothenberg and				
		of Medical Terms for the 5th edition, Rothenberg and	ΠÎ			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495226	B. WING		0:	3/12/2021	
	ROVIDER OR SUPPLIER NURSING AND REHAE	SLITATION CENTER	730 L	ET ADDRESS, CITY, STATE, ZIP CODE .UNENBURG HIGHW SVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X6) COMPLETION DATE	
F 909		e 94 ry of Medical Terms for the 5th edition, Rothenberg and	F 909		,		

State of Virginia

AND PLAN OF CORRECTION IDENTIFIE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		VA0050	B. WING		03/12/2021	
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER 730 LUN	DDRESS, CITY, STA ENBURG HIGH LE, VA 23947			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
An unannounced biennial State Licensure Inspection was conducted 3/9/21 through 3/12/21. Corrections are required for compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 90 certified bed facility was 50 at the time of the survey. The survey sample consisted of 35 Resident reviews. F 001 Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12 VAC 5 - 371 - 140 - B, C Based on staff interview and facility document review, it was determined the facility staff failed to review all policy and procedures on an annual basis.		F 001	Wayland Nursing and Rehabilitation acknowledges receipt of the Statest Deficiencies and proposes this Plat Correction to the extent that the surror of findings is factually correct and in compliance with the appliances and provisions of quality of caresidents. This Plan of Correction is submitted as a written allegation of compliance. Wayland Nursing and Rehabilitation Center's response to this Statement of Deficiencies nor does constitute an admission that any dis accurate. Wayland Nursing and Rehabilitation Center reserves the refute any of the deficiencies on this Statement of Deficiencies on this Statement of Deficiencies on the Statement of Defici	ment of in of immary order to cable are of s f in ciencies is e it efficiency right to is Informal		
	10:02 a.m. for the doci annual policy and prod On 3/11/2021 at 1:53 p (administrative staff manursing, was received, document titled, "QAP: performance improven This document failed to policy and procedure r An interview was cond	o.m., an email from ASM ember) #2, the director of This email contained a i (quality assurance nent) Revision Review." o evidence an annual		 F001~ The QAPI team was cal together for impromtu meeting 3/12/21 to review and accept a manuals fo the year of 2021. Adminstrator, DON, Medical D and Dept Heads met to review accept current manuals for 202 was placed into QAPI. Yearly reviews will be continue maintan reviewing the policy mand accepting them according! Will be reviewed in QAPI yearl 	on ill dept irector and 21 and d to nanuals	

LABORATORY DIRECTOR'S OR PROVIDERSYPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 03/17/2021 FORM APPROVED State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING. DAW B VA 0050 03/12/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XS) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) F 001 Continued From page 1 F 001 policy and procedure reviews were, ASM #2 stated they were having a quick QAPI meeting. this morning, for emergent things, to review all of the policy and procedures. When asked the last time the policy and procedures were reviewed, ASM #2 stated, "I can't tell you." An interview was conducted with ASM #1, the administrator, on 3/12/2021 at 9:48 a.m. When asked why the annual policy and procedure review was not completed, ASM #1 stated, "It got away from us, especially with the pandemic and the frequent change in the DON (director of nursing) position. ASM #1 made aware of the above concern on 3/12/2021 at approximately 10:00 a.m. An email request was made on 3/12/2021 at 10:26 a.m. to ASM #1 and ASM #2 for a policy related to the annual policy and procedure review. On 3/12/2021 at 10:42 a.m. ASM #2 responded and stated she could not locate a policy. No further information was provided prior to exit. 12 VAC 5 - 371 - 150 A - cross references to Federal Deficiency F 600 12 VAC 5 - 371 - 150 - cross references to Federal Deficiency F 623 and F 625

12 VAC 5 - 371 - 250 A - cross references to

12 VAC 5 - 371 - 250 F - cross references to Federal Deficiency F 656 and F 657

12 VAC 5 - 371 - 220 A - cross references to

Federal Deficiency F 641

Federal Deficiency F 698

State of Virginia STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY DENTIFICATION NUMBER: COMPLETED A. BUILDING: VA0050 B. WING 03/12/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY F 001 Continued From page 2 F 001 12 VAC 5 - 371 - 220 B - cross references to Federal Deficiency F 695 12 VAC 5 - 371 - 330 A - cross references to Federal Deficiency F 700 12 VAC 5 - 371 - 200 B. 3 - cross references to Federal Deficiency F 730 12 VAC 5 - 371 - 300 B - cross references to Federal Deficiency F 761 12 VAC 5 - 371 - 340 - cross references to Federal Deficiency F 812 12 VAC 5 - 371 - 370 G - cross references to Federal Deficiency F 909 12VAC5-371-140. Policies and Procedures: Staff F001-Licenses. . The files for LPN #3, LPN #5, CNA#6, See below citation and #7 were updated. License verification for staff will occur Based on staff interview and facility document upon employment and annually there review, it was determined that the facility staff after failed to evidence verification of a current license · License renewal data will be added to or certificate or perform reference checks in the facility's Employee Maintenance accordance with the laws of the State of Virginia, Update Program to Indicate when for four of 25 employee records reviewed, (LPN license is due. Evaluations and skills checklists will be (licensed practical nurse) #3, LPN #5, CNA entered into employee folders at the (certifled nursing assistant) #6 and CNA #7). 04/12/21 time of renewal. The findings included: On 3/11/21 at approximately 8:00 AM, the employee records for newly hired employees within the past two years were reviewed. Review of the employee records failed to produce evidence of license verifications or reference

State of Virginia

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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	
 		VA0050	8. WING		03/12/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STA	FE, ZIP CODE		
WAYLANI	D NURSING AND REHAB	ILITATION CENTER	ENBURG HIGHW	1		
<u></u>			LLE, VA 23947			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPI	LETE
F 001	Continued From page	3	F 001	y = 1 · · · · · · · · · · · · · · · · · ·		
	checks on file for four staff members					
	The employees identi	fied were;				
		al nurse) #3's employee				
	record was reviewed. LPN #3's employee record documented they were hired as an LPN with the facility on 10/21/20. Further review of LPN #3's				1-5 mm-1-5- e	
	employee record faile source license verifica				22	
	Department of Health	Professionals. The nursing				
	license for LPN #3 In 12/31/20.	the employee file expired			offer class action into a class	
		ecord was reviewed. LPN				
	#5's employee record documented they were hired as an LPN with the facility on 3/24/20.					
	Further review of LPN	#5's employee record			age a special	
	failed to evidence prin verification from the V				Light to a same or	
		The nursing license for				
	LPN #5 in the employ	se file expired 3/17/20.			distribution of the state of th	
	CNA (certified nursing	assistant) #6's employee				ĺ
		CNA #6's employee record			ggs.de	
		e hired as a CNA with the orther review of CNA #6's			1	
	employee record faile	d to evidence primary				
	Source license verifica	ition from the Virginia Professionals. The CNA				
		e file expired 1/31/20 and				
	CNA #6 was terminate	ad from facility on 2/27/20				
		ecord was reviewed. CNA				
		documented they were				
	hired as a CNA with th	ne facility on 4/16/19.				
	falled to evidence prim	nary source license			and the state of t	
	verification from the V				E.	
	mealin Professionals.	The CNA license in the				

State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING VA0050 03/12/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 001 Continued From page 4 F 001 employee file expired 3/31/20 and CNA #7 was terminated from facility on 7/22/20 An interview was conducted on 3/11/21 at 9:02 AM with OSM (other staff member) #7, the HR (human resources) coordinator. When asked who is responsible for license primary source verification, OSM #7 stated, "I only pull the original licenses after that the SDC (staff development coordinator) makes sure the licenses are current." An Interview was conducted on 3/11/21 at 9:48 AM with ASM (administrative staff member) #2, the director of nursing. When asked to speak with the staff development coordinator (SDC), ASM #2 stated, "The SDC is on family medical leave and has not been here since November I believe." When shown that the license PSV (primary source verification) for LPN #3 had a print date of 3/11/21 at 9:10 AM, ASM #2 stated, "I knew he renewed it and I checked it on line but I didn't print the copy to put in the book. I was trying to correct that before I brought the documents to you. I was the clinical coordinator. at the time I looked at this." When asked if the clinical coordinator role was similar to the ADON (assistant director of nursing), ASM #2 stated, "Yes, here the ADON and clinical coordinator are the same." An interview was conducted on 3/11/21 at 10:26 AM with ASM #2, the director of nursing. When asked to validate that LPN #5 had a name change and were the same person, ASM #2 stated, "Yes, they are the same person". On 3/11/21 at 10:35 AM, ASM #3, the clinical consultant brought a license PSV printed for LPN #5 at 10:30 am on 3/11/21, with expiration date of 11/30/21.

FORM APPROVED State of Virginia STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COMPLETED B. WING VA0050 03/12/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER KEYSVILLE, VA 23947 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 001 F 001 Continued From page 5 On 3/12/21 at 11:50 AM during the exit conference with ASM #4, the regional vice president ASM #4 asked, "They were working without a license? ASM #2, the director or nursing stated they had a current license but the facility did not have a copy of this". ASM #4, was asked how the facility is verifying that the licenses are current if they do not have license primary source verification? ASM #4 state, "I guess we weren't". The facility's policy "Validation of Nursing License" dated 1/12/2016, documented in part, "All licenses are validated with the board of nursing at the time of hire and at time of each renewal. All nursing assistants will provide their social security number for verification with the Virginia board of nursing". The state regulation 12VAC5-371-140 documented "E. Personnel policies and procedures shall include, but are not limited to: 3. An accurate and complete personnel record for each employee including: a. Verification of current professional license, registration, or certificate or completion of a required approved training course; b. Criminal record check; c. Verification that the employee has reviewed or received a copy of the job description ..." On 3/11/21 at approximately 11:50 AM, ASM #1, the administrator was made aware of the findings. No further information was provided prior to exit.