PRINTED: 05/10/2021 FORM APPROVED OMB NO. 0938-0391

	C 05/05/2021
İ	05/05/2021
JLO BE	COMPLETION DATE
construction to a construction this in	ued y, its als plan ity's en 5/21/21 er on of r fuse
ar Any not been ADL cans of	care
or a second of horse second as the second as	of this or at a construction of this or at a construction of this or at a construction of the facility of the

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be oxcused 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.

Calthinged

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	COMPLETED
		495255	B. WING		05/05/2021
		ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 50 MONTVUE DRIVE LURAY, VA 22835	
(X4) ID PREFIX TAG	/EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE DATE
F 677	until 2/22/21, a per The findings Includ 1. Resident #1 was 9/29/20. Resident were not limited to back pain. Reside (minimum data sei (assessment refer the resident as cog a possible 15 on th status. Section G physical help in pa Resident #1's com 9/30/20 documents potential for ADL. s (related to) OA (os stenosis, asthma, pulmonary disease pain, and muscle v falled to document baths and showers Review of Residen physician's order of the charge nurse in the resident's bath every Wednesday Review of Residen TARs (treatment a a bath was schedu being given on 2/2 note dated 2/27/21 bath was not come	of 11 days, and from 2/15/21 find of 7 days. le: s admitted to the facility on #1's diagnoses included but diabetes, asthma and low nt #1's quarterly MDS) assessment with an ARD ence date) of 4/14/21, coded gnitively intact, scoring 15 out of the brief interview for mental coded Resident #1 as requiring rt of bathing activity. prehensive care plan dated end, "(Resident #1) has the elf-care performance (sic) r/t teoarthritis), lumbar spinal COPD (chronic obstructive end) (lung disease), low back weakness." The care plan specific information regarding is at #1's clinical record revealed a ated 2/6/21 that documented and to sign off acknowledging was completed on day shift and Saturday. It #1's February and April 2021 diministration records) revealed alled and not documented as 7/21 and 4/17/21. A nurse's documented Resident #1's eleted. A nurse's note dated	F 677	preferences, to include residentification rights to refuse care. 3. The Director of Nursing/Designal will reeducate CNAs, LPNs, a RNs on the importance of offering and giving showers are residents' rights to refuse can This education will include, be not be limited to, offering showers on shower days and giving showers on shower days and updating plans of care to address individual residents' shower preferences. 4. The Director of Nursing/Designal develop a shower tracking log to ensure the residents' needs of showers are being on the residents' scheduled shower days. The Director of Nursing/Designee will perfor daily tracking assessment/au on all scheduled showers for weeks. The Director of Nursing/Designee will identificanty issues, patterns or trend report to the Quality Assurational Performance Improvement Committee at least quarterly	gnee nd and re. ut ys done m a dit 6 fy s and nce ent
	bath was not comp 4/17/21 documents	leted. A nurse's note dated ed the bath order but no further		·	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	(X3) DATE COMF	SURVEY
		495255	B. WING			l .	C /05/2021
NAME OF P	ROVIDER OR SUPPLIER	430200		ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	SPRINGS REHAB AND I	NURSING CENTER			MONTVUE DRIVE URAY, VA 22835	4	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	including the TAR, AD documentation and not 2021 and April 2021, if was provided full be 2/24/21 until 3/3/21, at 4/14/21 until 4/21/21, On 5/4/21 at 10:59 a.i. conducted with Residus ometimes she does a because the facility "done 5/5/21 at 10:49 a.i. was conducted with RRN #2 stated Residen baths/showers as schwas short staffed. On 5/5/21 at 3:15 p.m member) #1 was mad concern. The facility policy regatiled to document infull bathing/showers solid 2:08 p.m., ASM #2 do follows CMS (Centers Services) guidelines for No further information COMPLAINT DEFICIES.	ident #1's clinical record, DL (activity of daily living) urses' notes for February falled to reveal that Resident hathing/showers from period of 7 days, and from a period of 7 days. m., an interview was ent #1. Resident #1 stated hot receive her showers hoes not have enough help." m., a telephone interview N (registered nurse) #2. Int #1 did not always receive eduled because the facility J. ASM (administrative staff e aware of the above arding showering a resident formation about how often hould occur. On 5/5/21 at cumented the facility for Medicare and Medicaid for twice a week. was presented prior to exit. ENCY Smitted to the facility on	F	677			
	2. Resident #2 was at 1/31/17. Resident #2	Imitted to the facility on 's diagnoses included but					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING R. WING 05/05/2021 495255 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 30 MONTVUE DRIVE SKYVIEW SPRINGS REHAB AND NURSING CENTER LURAY, VA 22835 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 677 F 677 Continued From page 3 were not limited to congestive heart failure, chronic kidney disease and urinary tract infection. Resident #2's quarterly MDS (minimum data set) with an ARD (assessment reference date) of 4/26/21, coded the resident as being cognitively intact, scoring 15 out of a possible 15 on the brief interview for mental status. Section G coded Resident #2 as being totally dependent on staff for bathing. Resident #2's comprehensive care plan dated 2/1/17 documented, "(Resident #2) has the potential for ADL self-care performance deficit r/t (related to) Psychotic disorder with hallucinations, osteoarthritis, chronic pain, muscle weakness." The care plan falled to document specific information regarding baths and showers. Review of Resident #2's clinical record revealed a physician's order dated 12/11/20 that documented the charge nurse had to sign off acknowledging the resident's bath was completed on day shift every Monday and Thursday. Review of Resident #2's February 2021 TARs (treatment administration records) revealed a bath was scheduled and not documented as being given on 2/8/21, 2/11/21 and 2/18/21. A nurse's note dated 2/8/21 documented Resident #2's bath was not given. A nurse's note dated 2/11/21 documented Resident #2's bath was not administered. A nurse's note dated 2/18/21 documented Resident #2's bath was not performed.

Further review of Resident #2's clinical record, including the TAR, ADL documentation and nurses' notes for February 2021, failed to reveal that Resident #2 was provided a full bath and/or

PRINTED: 05/10/2021

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SI COMPLE		
				 :	С
		495255	B, WING		05/05/2021
	ROVIDER OR SUPPLIER SPRINGS REHAB AND I	VURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP.CODE 30 MONTVUE DRIVE	•
OW! AICAN	SEKINGS KEHADARD I	torcito onivina		LURAY, VA 22835	
(X4) ID PREFIX TAG	(EACH DÉFICIENC)	NTEMENT 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 APPROPRIA DEFICIENCY)	
	days, and from 2/15/2 days. On 5/4/21 at 11:40 a.r. conducted with Residu that in the past, there she was not getting here. On 5/5/21 at 10:12 a.r. was conducted with Linurse) #3. LPN #3 stawere only two CNAs of #2's unit (a 60 bed unit CNAs tried to give showned that the conducter of the conducter. When the conducter of the c	ntil 2/15/21, a period of 11 11 until 2/22/21, a period of 7 m., an interview was ent #2. Resident #2 stated was "Not a lot of help" and er baths. m., a telephone interview PN (licensed practical ated that at times, there during day shift on Resident it). LPN #3 stated the owers and baths but #2 did not receive her baths. " ASM (administrative staff e aware of the above was presented prior to exit. ENCY ff 2) Staff. sufficient nursing staff with etencies and skills sets to elated services to assure tain or maintain the highest mental, and psychosocial ident, as determined by and individual plans of care umber, acuity and	F 67	Preparation and/or execution of the does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be contast an admission of fault by the facing employees, agents or other individed who draft or may discussed in this response and plan of correction. The of correction is submitted as the fact credible allegation of compliance. 1. Residents #1, and #2 have receiving their routine show their shower days and plan care have been updated to address the residents' show needs and preferences, to include residents' rights to care. 2. An audit has been performed all residents to ensure they	strued flity, its fluals his plan cility's been 5/21/21 wer on s of ver refuse ed on have
	and considering the nudiagnoses of the facili			received their showers on t	heir.

F725 Continued From page 5 at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when walved under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when walved under paragraph (e) of this section, licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, olinical record review, facility staff falled to maintain sufficient nursing staff for two of 5 residents in the survey sample, Resident #1 on the survey sample, Resident #1 on the facility staff falled to provide full bathing/showers for Resident #2 from 2/4/21 until 3/3/21, a period of 7 days, and field to provide full bathing/showers for Resident #2 from 2/4/21 until 3/3/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 2/15/21 until 2/22/21, a		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTI	RUCTION	ŀ	PLETED
STREET ADDRESS, CITY, STATE, ZIP CODE 3 MONTYUE DRIVE LURAY, VA. 2835 FROM CORRECTIVE ACTION OF CORRECTION PREFIX (CA) ID PREFIX (CA) ID PROPERTY TAG FROM CORRECTIVE ACTION BEOCHMANT OF DEPTICIONALS (CA) ID PREFIX (CA) ID PROPERTY OF DEPTICIONAL BEOCHMANT OF CORRECTION (CA) ID PREFIX (CA) ID PROPERTY OF DEPTICIONAL BEOCHMANT OF CORRECTION (CA) ID PREFIX (CA) ID PROPERTY OF DEPTICIONAL BEOCHMANT OF CORRECTION (CA) ID PREFIX (CA) ID PROPERTY OF DEPTICIONAL BEOCHMANT OF CORRECTION (CA) ID PREFIX (CA) ID PROPERTY OF DEPTICIONAL BEOCHMANT OF CORRECTION (CA) ID PREFIX (CA) ID PROPERTY OF CORRECTION (CA) ID PREFIX (CA) ID PROPERTY OF DEPTICIONAL BEOCHMANT OF CORRECTION (CA) ID PREFIX (CA) ID PROPERTY OF DEPTICIONAL BEOCHMANT OF CORRECTION (CA) ID PREFIX (CA) ID PROPERTY OF CORRECTION (CA) ID PROPERTY OF CORRECTION (CA) ID PREFIX (CA) ID PROPERTY OF CORRECTION (CA) ID PREFIX (CA) ID PROPERTY OF CORRECTION	•		40-70-1	D 16ffNG	•		1	•
SKYVEW SPRINGS REHAB AND NURSING CENTER SUMARY STRUBULATION OR 150 DESTRUBINGES (DAY TOTAL STATE OF THE APPROPRIATE AREA STATE OF THE APPROPRIATE APP			495255	B, Ward	CTDEET A	DODESE CITY STATE TIP CODE	1 03.	03/2021
CAN ID SIMMARY STATEMENT OF DEFICIENCIES ID PROFESS GRAND ADDRESS PROVIDERS PLAN OF CORRECTION GRAND ADDRESS PLAN OF CRESS PLAN OF CORRECTION GRAND ADDRESS PLAN OF CRESS PLAN	NAME OF P	ROVIDER OR SUPPLIER				•		
F725 Continued From page 5 at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when walved under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when walved under paragraph (e) of this section, licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, olinical record review, facility staff falled to maintain sufficient nursing staff for two of 5 residents in the survey sample, Resident #1 on the survey sample, Resident #1 on the facility staff falled to provide full bathing/showers for Resident #2 from 2/4/21 until 3/3/21, a period of 7 days, and field to provide full bathing/showers for Resident #2 from 2/4/21 until 3/3/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 11 days, and from 2/15/21 until 2/22/21, a period of 2/15/21 until 2/22/21, a	SKYVÆW	SPRINGS REHAB AND I	NURSING CENTER					1
F 725 Conlinued From page 5 at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when walved under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when walved under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, facility document review and in the course of complaint investigation, it was determined that the facility staff falled to maintain sufficient nursing staff for two of 5 residents in the survey sample, Residents#1 and #2. Due to insufficient CNA (certified nursing assistant) staffing, the facility staff falled to provide full bathing/showers for Resident #2 from 2/4/21 until 3/3/21, a period of 7 days, and failed to provide full bathing/showers for Resident #2 from 2/4/21 until 2/15/21, a period of 7 days, and failed to provide full bathing/showers for Resident #2 from 2/4/21 until 2/15/21, a period of 7 days, and failed to provide full bathing/showers for Resident #2 from 2/4/21 until 2/15/21, a period of 7 days, and failed to provide full bathing/showers for Resident #2 from 2/4/21 until 2/15/21, a period of 7 days, and failed to provide full bathing/showers for Resident #2 from 2/4/21 until 2/15/21, a period of 7 days, and failed to provide full bathing/showers for Resident #2 from 2/4/21 until 2/15/21, a period of 7 days, and failed to provide full bathing/showers for Resident #2 from 2/4/21 until 2/15/21, a period of 7 days, and failed to provide full bathing/showers for Resident #2 from 2/4/21 until 2/15/21, a period of 7 days, and failed to provide full bathing/showers for Resident #2 from 2/4/21 until 2/15/21, a period of	PREFIX	(FACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE NATE	(X5) COMPLETION DATE
or 7 days. perform a daily tracking assessment/audit on all scheduled showers for 6 weeks. 1. Due to Insufficient CNA staffing, the facility staff	F 725	at §483.70(e). §483.35(a)(1) The factory sufficient numbers types of personnel on nursing care to all restresident care plans: (i) Except when waive this section, licensed in this section are all consed in the section of this section in the section of this section in the section of this REQUIREMENT by: Based on resident into clinical record review, and in the course of comes determined that the maintain sufficient nurresidents in the survey #2. Due to insufficient CN assistant) staffing, the provide full bathing/sh between 2/24/21 until and from 4/14/21 until and failed to provide fixesident #2 from 2/4/21 this provide in the section in the section of 7 days. The findings include:	illity must provide services of each of the following a 24-hour basis to provide idents in accordance with ad under paragraph (e) of nurses; and onnel, including but not when waived under section, the facility must nurse to serve as a charge duty. is not met as evidenced erview, staff interview, facility document review omplaint investigation, it he facility staff failed to sing staff for two of 5 y sample, Residents #1 and A (certified nursing facility staff falled to owers for Resident #1 3/3/21, a period of 7 days, 4/21/21, a period of 7 days, ull bathing/showers for 21 until 2/15/21, a period of 5/21 until 2/22/21, a period of 5/21 until 2/22/21, a period	F 72	73	perform showers and AD for residents. Those residents and preferences, to include residents and preferences, to include residents rights to refuse. The Director of Nursing/D has educated the shower on the importance of offerences and giving showers, proportion of giving ADL care, and registration had included, because to refuse care. This education had included, because on shower days a giving showers on shower days and updating plans of care address individual resider shower preferences. The Director of Nursing/D will develop a shower tracklog to ensure the shower able to meet the resident of showers and that show being done on the resident scheduled shower days. The Director of Nursing/Design perform a daily tracking assessment/audit on all	L needs ents' pdated needs de care. lesignee team ering er way sidents' and days e to lts' esignee king team is s' needs ers are he nee will	

NAME OF PROVIDER OR SUPPLIER SKYVIEW SPRINGS REHAB AND NURSING CENTER PREFIX GEACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FREETY TAG Continued From page 6 falled to provide full bathing/showers for Resident #1 from 21/24/21 until 3/3/21, a period of 7 days and from 4/14/21 until 4/21/21, a period of 7 days. Resident #1 was admitted to the facility on 9/29/20. Resident #1's quarterly MIDS (minimum data set) assessment reference date) of 4/14/21, coded the resident as cognifively intact, scoring 15 out of a possible 15 on the brief interview for mental status. Section G coded Resident #1 as requiring physical help in part of bathing activity. Resident #1's comprehensive care plan dated 9/30/20 documented, "(Resident #1) has the potential for ADL self-care performance (sic) rit (related to) OA (coteoarthritis), lumbar spinal stenosis, asthma, COPD (chronic obstructive pulmonary disease) (lung disease), low back pain, and muscle weakness." The care plan failed to document specific information regarding baths and showers.		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER SKYVIEW SPRINGS REHAB AND NURSING CENTER Author			:	71. 00100	,,,,,		ļ	С
SKYVIEW SPRINGS REHAB AND NURSING CENTER (KA) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 725 Continued From page 6 failed to provide full bathing/showers for Resident #1 from 2/24/21 until 3/3/21, a period of 7 days. Resident #1 was admitted to the facility on 9/29/20. Resident #1's quarterly MDS (minimum data set) assessment reference date) of 4/14/21, coded the resident as cognitively intact, scoring 15 out of a possible 15 on the brief interview for mental status. Section 6 coded Resident #1 as requiring physical help in part of bathing activity. Resident #1's comprehensive care plan dated 9/30/20 documented, "(Resident #1) has the potential for ADL self-care performance (sic) rit (related to) OA (osteoarthritis), lumbar spinal stenosis, asthma, COPD (chronic obstructive pulmonary disease) (lung disease), low back pain, and muscle weakness." The care plan failed to document specific information regarding		!	495255	B. WING			05	/05/2021
F 725 F 725 Continued From page 6 falled to provide full bathing/showers for Resident #1 was admitted to the facility on 9/29/20. Resident #1's diagnoses included but were not limited to diabetes, asthma and low back pain. Resident #1's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 4/14/21, coded the resident as cognitively intact, scoring 15 out of a possible 15 on the brief interview for mental status. Section G coded Resident #1's nature physical help in part of bathing activity. Resident #1's comprehensive care plan dated 9/30/20 documented, "(Resident #1) has the potential for ADL self-care performance (sic) r/t (related to) OA (osteoarthits), lumbar spinal stenosis, asthma, COPD (chronic obstructive pulmonary disease) (lung disease), low back pain, and muscle weakness." The care plan failed to document specific information regarding			NURSING CENTER		3	0 MONTVUE DRIVE		
Continued From page 6 falled to provide full bathing/showers for Resident #1 from 2/24/21 until 3/3/21, a period of 7 days and from 4/14/21 until 4/21/21, a period of 7 days. Resident #1 was admitted to the facility on 9/29/20. Resident #1's diagnoses included but were not limited to diabetes, asthma and low back pain. Resident #1's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 4/14/21, coded the resident as cognitively intact, scoring 15 out of a possible 15 on the brief interview for mental status. Section G coded Resident #1 as requiring physical help in part of bathing activity. Resident #1's comprehensive care plan dated 9/30/20 documented, "(Resident #1) has the potential for ADL self-care performance (sic) rt/t (related to) OA (osteoarthritis), lumbar spinal stenosis, asthma, COPD (chronic obstructive pulmonary disease) (lung disease), low back pain, and muscle weakness." The care plan failed to document specific information regarding	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
Review of Resident #1's clinical record revealed a physician's order dated 2/6/21 that documented the charge nurse had to sign off acknowledging the resident's bath was completed on day shift every Wednesday and Saturday. Review of Resident #1's February and April 2021 TARs (treatment administration records) revealed a bath was scheduled and not documented as being given on 2/27/21 and 4/17/21. A nurse's note dated 2/27/21 documented Resident #1's bath was not completed. A nurse's note dated 4/17/21 documented the bath order but no further information.	F 725	falled to provide full by #1 from 2/24/21 until 3 and from 4/14/21 until 3 and from 4/14/21 until 3 and from 4/14/21 until 4 Resident #1 was adm 9/29/20. Resident #1 were not limited to dia back pain. Resident # (minimum data set) as (assessment reference the resident as cognitil a possible 15 on the be status. Section G code physical help in part of Resident #1's compre 9/30/20 documented, potential for ADL self- (related to) OA (osteos stenosis, asthma, COI pulmonary disease) (in pain, and muscle weal failed to document spe baths and showers. Review of Resident #1 physician's order date the charge nurse had the resident's bath was every Wednesday and Review of Resident #1 TARs (treatment admir a bath was scheduled being given on 2/27/21 note dated 2/27/21 do bath was not complete 4/17/21 documented til	athing/showers for Resident 3/3/21, a period of 7 days 4/21/21, a period of 7 days. Itted to the facility on s diagnoses included but betes, asthma and low 4/15 quarterly MDS seessment with an ARD e date) of 4/14/21, coded wely intact, scoring 15 out of orief Interview for mental led Resident #1 as requiring f bathling activity. The care plan dated "(Resident #1) has the care performance (sic) r/t arthritis), lumbar spinal PD (chronic obstructive ung disease), low back kness." The care plan eclfic information regarding s's clinical record revealed a d 2/6/21 that documented to sign off acknowledging is completed on day shift I Saturday. I's February and April 2021 instration records) revealed and not documented as and 4/17/21. A nurse's cumented Resident #1's ed. A nurse's note dated	F	725	will identify any issues, pa or trends and report to the Quality Assurance and Performance Improvemen	tterns e nt	

PRINTED: 05/10/2021 FORM APPROVED OMB NO. 0938-0391

and the second s

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		DNSTRUCTION		ATE SURVEY
			A. BUILL	11405			С
		495255	B, WING				05/05/2021
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	 ',	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
SKANLEIV	SPRINGS REHAB AN	D NURSING CENTER		30 M	ONTVUE DRIVE		
SKI VIEW	SPRINGS REIMBAR	D NORONO OLIVILIA	<u> </u>	LUR	AY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIE!	STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF. TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 725	Continued From pa	ge 7	F	725			
		esident #1's clinical record, ADL (activities of daily living)					
	documentation and	nurses' notes for February I, failed to reveal that Resident					
	#1 was provided full	bathing/showers from a period of 7 days, and from					
		1, a period of 7 days.					
		staff schedule for 2/27/21					
	on Resident #1's un	were scheduled for day shift it (a 60 bed unit) and another					
		on day shift but was etween Resident #1's unit and	-				1
	the other unit. Review	ew of a nursing staff schedule	1				
	for 4/17/21 revealed for day shift on Resi	three CNAs were scheduled dent #1's unit.	:				
		ı.m., an interview was dent #1. Resident #1 stated					
		not receive her showers		-			1
ļ	because the facility '	'does not have enough help."					
		m., a telephone interview was					
		#1. CNA #1 stated some been short staffed with CNAs					
Ì	and residents did no	t receive showers but the					
	CNAs did the best th residents.	ey could to care for the					
		.m., a telephone interview OSM (other staff member)		ľ			
	#1, the nursing sche	duling coordinator. OSM #1					
	stated she tries to so	hedule six CNAs for each					j
		hift, the shift responsible for rs. OSM #1 stated the	ľ				
		ort on CNAs" but she was					
		on social media and agency					
	staff had been hired s	so staffing was getting	ł	- 1			1 [

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		E SURVÉY IPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		000	C
		495255	B. WING		05	6/05/2021
	ROVIDER OR SUPPLIER SPRINGS REHAB AND I	IURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 725	better. On 5/5/21 at 10:49 a.r was conducted with R RN #2 stated Residen baths/showers as sch was short staffed. RN facility has now hired there were not enough residents' baths/showers as the rewere not enough residents' baths/showers as the rewere not enough residents' baths/showers as the residents' baths/showers and concern. The facility staffing polyfacility provides sufficithe skills and compete care and services for a with resident care plar assessment." No further information COMPLAINT DEFICIE 2. The facility staff fails bathing/showers for R 2/15/21, a period of 11 until 2/22/21, a period Resident #2 was adml 1/31/17. Resident #2's were not limited to corchronic kidney disease Resident #2's quarterly with an ARD (assessment).	m., a telephone interview N (registered nurse) #2. It #1 did not always receive eduled because the facility I #2 stated she thought the agency staff but in the past, In CNAs to complete ers. In ASM (administrative staff e aware of the above Iticy documented, "Our eent numbers of staff with ency necessary to provide all residents in accordance as and the facility was presented prior to exit. ENCY ed to provide full esident #2 from 2/4/21 until I days, and from 2/15/21 of 7 days. Itted to the facility on s diagnoses included but	F 725			
	intact, scoring 15 out of	of a possible 15 on the brief				

MANIE OF PROMIDER OR SUPPLIER SKYVIEW SPRINGS REHAB AND NURSING CENTER CHAPTY AND STREET ADDRESS, CITY, STATE, 2P CODE 30 MONTYLUE DRIVE LURAY, VA 22355 PRESTADDRESS, CITY, STATE, 2P CODE 30 MONTYLUE DRIVE LURAY, VA 22355 DE CRONDERS OR AND OF CONSECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPSINGED TO THE APPROPRIATE PRESTA TAG F725 Continued From page 9 interview for mental status. Section G coded Resident #2's comprehensive care plan dated 21/117 documented, "(Resident #2) has the potential for ADL self-care performance deflot tri (related to) Peyphotic disorder with haluchaitors, osteoarthritis, chronic pain, muscle weakness." The care plan falled to document specific information regarding baffus and showers. Review of Resident #2's clinical record revealed a physician's order dated 12/11/20 that documented the charge nurse had to sign off acknowledgling the resident's bath was completed on day shift every Monday and Thursday. Review of Resident #2's Potunay 2021 TARs (treatment administration records) revealed a bath was scheduled and not documented as being given on 29/21, 21/121 and 21/12/1. A hurse's note dated 29/13/21 documented Resident #2's bath was not administered. A nurse's note dated 29/13/21 documented Resident #2's bath was not administered. A nurse's note dated 29/13/21 documented Resident #2's bath was not administered. A nurse's note dated 29/13/21 documented Resident #2's bath was not administered. A nurse's note dated 29/13/21 documented Resident #2's bath was not administered. A nurse's note dated 29/13/21 documented Resident #2's bath was not performed. Further review of Resident #2's clinical record, including the TAR, ADL documentation and nurses' notes for February 2021, failed to reveal that Resident #2' was provided a full bath and/or shower from 24/21 until 2/15/21, a period of 11 days, and from 21/15/21 until 2/15/21, a period of 11 days, and from 21/15/21 until 2/15/21, a period of 11 days.		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		E CONSTRUCTION		SURVEY PLETED
MANE OF PROVIDER OR SUPPLIER SKYVIEW SPRINGS REHAB AND NURSING CENTER DATE OF THE STATE OF THE				İ			I	
SKYVIEW SPRINGS REHAB AND NURSING CENTER SIMMARY SYNTEMENT OF DEPICIENCY SIRVERS RECECCION OF DEPICIENCY AND STREET RECECCION OF DEPICIENCY AND STREET RECECCION OF STREET OF TAG CROSS-REPTENCE OF THE RAPPROPRIATE DEPICIENCY OF THE RESULATORY OR LSO IDENTIFYING INFORMATION) F 7.25 Conflinued From page 9 interview for mental status. Section G coded Resident #2's comprehensive care plan dated 2/11/17 documented, "(Resident #82) has the potential for ADL self-care performance deficil the resident for psycholic disorder with hallucinations, osteoarthrilis, ohronic pain, muscle weakness." The care plan failed to document specific information regarding baths and showers. Review of Resident #2's clinical record revealed a physician's order dated 12/11/20 that documented the charge nurse had to sign off acknowledging the resident's bath was completed on day shift every Monday and Thursday. Review of Resident #2's February 2021 TARs (treatment administration records) revealed a bath was scheduled and not documented as being given on 2/8/21, 2/11/21 and 2/18/21, A nurse's note dated 2/8/21 documented Resident #2's bath was not performed. Further review of Resident #2's bath was not performed. Further review of Resident #2's clinical record, including the TAR, ADL documentation and nurses' notes for February 2021, failed to reveal that Resident #2's path vas not of 1/21/21 and 1/21/21 and 1/21/221, a period of 11 days, and from 2/16/21 until 2/15/21, a period of 17 days, and from 2/16/21 until 2/15/21, a period of 17 days, and from 2/16/21 until 2/21/221, a period of 7			495255	B. WING			05	/05/2021
PREFIX TAG CROSS-REFERENCY AUSTRE PRECEDED BY FULL TAG CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIAT			NURSING CENTER		:	30 MONTVUE DRIVE		
interview for mental status. Section G coded Resident #2's comprehensive care plan dated 2/1/17 documented, "(Resident #2) has the potential for ADL self-care performance deficit r/t (related to) Psychotic disorder with hallucinations, osteoarthritis, chronic pain, muscle weakness." The care plan failed to document specific information regarding baths and showers. Review of Resident #2's clinical record revealed a physician's order dated 12/11/20 that documented the charge nurse had to sign off acknowledging the resident's bath was completed on day shift every Monday and Thursday. Review of Resident #2's February 2021 TARs (treatment administration records) revealed a bath was scheduled and not documented as being given on 2/8/21, 2/11/21 and 2/18/21. A nurse's note dated 2/8/21 documented Resident #2's bath was not given. A nurse's note dated 2/11/21 documented Resident #2's bath was not administered. A nurse's note dated 2/18/21 documented Resident #2's bath was not performed. Further review of Resident #2's bath was not performed. Further review of Resident #2's bath was not performed. Further review of Resident #2's clinical record, including the TAR, ADL documentation and nurses' notes for February 2021, failed to reveal that Resident #2 was provided a full bath anofor shower from 2/4/21 until 2/15/21, a period of 11 days, and from 2/15/21 until 2/15/21, a period of 7	PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
Review of a nursing staff schedule for 2/8/21 revealed two CNAs and a restorative aide were	F 7,25	interview for mental si Resident #2 as being for bathing. Resident #2's compre 2/1/17 documented, "potential for ADL self-(related to) Psychotic osteoarthritis, chronic The care plan failed to information regarding Review of Resident #2 physician's order date the charge nurse had the resident's bath wa every Monday and Th Review of Resident #2 (treatment administrated bath was scheduled a being given on 2/8/21, nurse's note dated 2/8 #2's bath was not give 2/11/21 documented Fadministered. A nursed documented Resident performed. Further review of Resincluding the TAR, AD nurses' notes for Febrithat Resident #2 was a shower from 2/4/21 undays, and from 2/15/2 days. Review of a nursing stemans and stemans and stemans and stemans and from 2/15/2 days.	tatus. Section G coded totally dependent on staff thensive care plan dated (Resident #2) has the care performance deficit r/t disorder with hallucinations, pain, muscle weakness." o document specific baths and showers. 2's clinical record revealed a dd 12/11/20 that documented to sign off acknowledging s completed on day shift ursday. 2's February 2021 TARs from records) revealed a nd not documented as 2/11/21 and 2/18/21. A sylladocumented Resident m. A nurse's note dated Resident #2's bath was not as note dated 2/18/21 #2's bath was not dent #2's clinical record, L documentation and uary 2021, failed to reveal provided a full bath and/or still 2/15/21, a period of 7 aff schedule for 2/8/21	F	725			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	ESURVEY PLETED
¥ ,		495255	B. WING			C /05/2021
	ROVIDER OR SUPPLIER SPRINGS REHAB AND		<u> </u>	30	REET ADDRESS, CITY, STATE, ZIP CODE MONTVUE DRIVE JRAY, VA 22835	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 725	60 bed unit). Review for 2/11/21 revealed to aide were scheduled #2's unit. Review of 2/18/21 revealed two were scheduled for dunit. On 5/4/21 at 11:40 a. conducted with Residents in the past, there she was not getting here. She was not getting here. Conducted with CNA days the facility had be and residents did not CNAs did the best the residents. On 5/5/21 at 10:12 a. was conducted with L nurse) #3. LPN #3 st was really struggling a several employees questated that at times, tilduring day shift on Residents. On 5/5/21 at 10:26 a. was conducted with CNAs tried but sometimes Reside baths. On 5/5/21 at 10:26 a. was conducted with CNAs tried but sometimes Reside baths.	ift on Resident #2's unit (a of a nursing staff schedule wo CNAs and a restorative for day shift on Resident a nursing staff schedule for CNAs and a restorative aide ay shift on Resident #2's m., an interview was lent #2. Resident #2 stated was "Not a lot of help" and er baths. m., a telephone interview was leen short staffed with CNAs receive showers but the ey could to care for the m., a telephone interview PN (licensed practical ated at one point the facility	F	725		

NAME OF PROVIDER OR SUPPLIER SKYVIEW SPRINGS REHAB AND NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 725 Continued From page 11 posting job offerings on social media and agency staff had been hired so staffing was getting better. On 5/5/21 at 3:15 p.m., ASM (administrative staff member) #1 was made aware of the above concern. No further information was presented prior to exit. COMPLAINT DEFICIENCY	AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER SKYVIEW SPRINGS REHAB AND NURSING CENTER SIREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835 [X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 725 Continued From page 11 posting job offerings on social media and agency staff had been hired so staffing was getting better. On 5/5/21 at 3:15 p.m., ASM (administrative staff member) #1 was made aware of the above concern. No further information was presented prior to exit.			, ,05255	B. WING	-		
SKYVIEW SPRINGS REHAB AND NURSING CENTER CAH 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 SHOULD BE COMPLETED TAG CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 725	NAME OF P	POVIÑER OR SUPPLIER	433233				
Computer Computer				.]			
F 725 Continued From page 11 posting job offerings on social media and agency staff had been hired so staffing was getting better. On 5/5/21 at 3:15 p.m., ASM (administrative staff member) #1 was made aware of the above concern. No further information was presented prior to exit.	SKYVIEW	SPRINGS REHAB AND I	NURSING CENTER		LURAY, VA 22835		
posting job offerings on social media and agency staff had been hired so staffing was getting better. On 5/5/21 at 3:15 p.m., ASM (administrative staff member) #1 was made aware of the above concern. No further information was presented prior to exit.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	HE APPROPRIATE DATE) ETION E
	TAG F 725	Continued From page posting job offerings of staff had been hired staff had been hired staff had staff had been hired had been hired had been hired had been hired had been hired had been hired had been hired had been hired hired had been hired had been hired hired hired had been hired hired hired hired hired had been hired	on social media and agency of staffing was getting ASM (administrative staffing aware of the above was presented prior to exit.		725)	G